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Eldercare in Canada: Context,
Content and Consequences



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Statistics Canada
Housing, Family and Social Statistics Division

Government
Publications

Eldercare in Canada: Context, Content and Consequences

**Norah Keating, Janet Fast, Judith Frederick,
Kelly Cranswick and Cathryn Perrier**

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November 1999

Catalogue no. 89-570-XPE

Frequency: Occasional

ISBN 0-660-17823-0

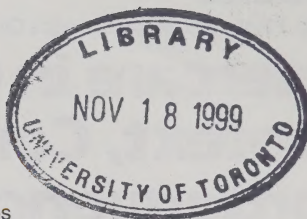
Ottawa

La version française de cette publication est disponible sur demande (n° 89-570-XPF au catalogue).

Note of appreciation

Canada owes the success of its statistical system to a long-standing partnership between Statistics Canada, the citizens of Canada, its businesses and governments. Accurate and timely statistical information could not be produced without their continued cooperation and goodwill.

Canadian Cataloguing in Publication Data



Main entry under title:

Eldercare in Canada: Context, content and consequences

Issued also in French under title:

Soins aux personnes âgées au Canada : Contexte, contenu, et conséquences.

ISBN 0-660-17823-0

CS89-570-XPE

1. Aged – Care – Canada – Statistics. 2. Caregivers – Canada – Statistics.

I. Statistics Canada. Housing, Family and Social Statistics Division.

II. Keating, Norah.

HQ1064 C3 E42 1999 362.6'0971'021 C99-988040-3

Symbols

The following standard symbols are used in Statistics Canada publications:

- .. figures not available.
- ... figures not appropriate or not applicable.
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- amount too small to be expressed.
- ^p preliminary figures.
- ^r revised figures.
- x confidential to meet secrecy requirements of the Statistics Act.

The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences - Permanence of Paper for Printed Library Materials, ANSI Z39.48 - 1984.



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PREFACE

Over the next 25 years the population of Canada aged 65 and over is expected to more than double. As a result of this aging of Canada's population, coupled with changes to Canada's health and social programs, there is an increased focus on issues related to eldercare and social support for seniors.

Statistics Canada's first General Social Survey (GSS), conducted in 1985, focused on the topic of health; however, it included a special module on social support for seniors. The topic was revisited as part of the 1990 General Social Survey on Family and Friends; however, again, content was somewhat limited. In view of the increasing importance of issues related to social support, a decision was made to have the issue of social support as the core topic of the 1996 General Social Survey, allowing for much more detailed investigations of the topic.

This monograph provides the first detailed analysis of results of the 1996 GSS. The purpose of the monograph is to provide an initial analysis of the nature and extent of informal eldercare in Canada for the subpopulation of seniors who require help because of a long-term health or activity limitation.

The monograph was a collaborative effort by researchers at the University of Alberta and Statistics Canada. At the University of Alberta, the research project was led by Norah Keating and Janet Fast, while Judith Frederick and Kelly Cranswick were the principal collaborators at Statistics Canada.

Douglas A. Norris
Director
Housing, Family and Social Statistics Division
Statistics Canada

ACKNOWLEDGEMENTS

In addition to the main authors, many individuals contributed to the preparation of the monograph. At the University of Alberta, Nancy South, Tracey Lapierre and Agnes Pieracci provided research and technical support. At Statistics Canada, Monique Hickey was responsible for coordinating all of the production work. The production and editing team included Janis Camelon, Elizabeth Irving, Sherry Galey, Shirley Li, Fiona Mac Donald, Colleen Thompson, Louise Demers and Louise Simard. A special thanks is owed to Ed Praught who was the survey manager for the 1996 General Social Survey. Ed provided invaluable advice on the complex dataset to the research team throughout the project.

Special thanks are also owed to Neena Chappell, Betty Havens, Leroy Stone, Frank Fedyk and Louise Plouffe, who reviewed an earlier draft of the monograph and provided many helpful comments and suggestions.

CHAPTER 1

INFORMAL CAREGIVING

Why informal caregiving? Why now?

During the 1990s, eldercare has moved toward centre stage on the national policy agenda. The pressure of an aging population, along with a perceived lack of resources for health, income security and social services, has led to a call for new ways to provide care to Canada's seniors. These new ways are based on a philosophy that emphasizes the provision of services to frail seniors by people who have formal and informal relationships with them. A tenet of this philosophy is that the most responsive caregiving approaches are those that allow seniors to remain part of the community.

Informal caregivers are key players in these partnerships. The care they give is seen as high quality and important in helping seniors maintain community and family connections. Informal care is also perceived to be less expensive than formal care, at least from a public expenditure perspective.

The new emphasis on informal care raises questions about the capacity of the informal sector to maintain or increase its caring activity. Angus, Auer, Cloutier and Albert (1995) estimate that over 90% of eldercare in Canada is provided informally. Yet, the continued pressures of demography and dwindling dollars have placed increasing demands on the informal sector.

The purpose of this book is to describe the nature, extent and consequences of informal eldercare in Canada for seniors with high care needs. Chapter 2 describes the seniors who are receiving care and highlights their characteristics by placing them in the context of all Canadian seniors. Although seniors with high care needs living in the community form only a small proportion of all seniors, their care requirements make them vulnerable to institutionalization.

Chapter 3 describes the people who give informal care to seniors in Canada. Detailed analyses of the characteristics of the women and men who provide different types and amounts of care illustrate the complexity of informal caregiving.

Chapter 4 examines the ways that caregiving activities can affect caregivers. The analysis of the impacts—which range from guilt, burden, and postponed career and educational opportunities to employment and socioeconomic impacts—illustrates the hidden costs incurred by care providers.

Chapter 5 examines the significance of these patterns of care for the planning of policies and programs for an aging population. The findings are synthesized into a set of issues concerning Canada's resources for informal care and the likely costs and benefits of increased demands on those resources.

Setting the stage

It is important to define key concepts at the outset. Operational definitions will be provided in each chapter as needed for the analyses being presented.

Informal caregivers: These people provide a variety of services to seniors. The main feature that distinguishes an informal caregiver is the personal history that exists between giver and recipient—one that is based on kinship or other affective ties (Hooyman 1993; National Advisory Council on Aging [NACA] 1990). In contrast, formal care is based on client–agency relationships rather than on the personal history of the caregiver and the care recipient. Most formal caregivers are employees of direct service organizations (Cantor 1991).

Informal relationships can be more or less voluntary, depending upon the nature of the relationship between the caregiver and recipient. For example, kinship ties make family members more obliged to help than do the ties between friends who are most likely to provide assistance in the absence of kin (Qureshi 1990; Wenger 1997). Family and friends of the recipient are considered to be the major providers of informal eldercare (Cantor 1991).

Caregiving tasks: Although there is no overall agreement on what comprises the complete set of caregiving tasks provided to a senior, common task categories are: personal care; household activities; shopping and transportation; financial management; emotional support; and monitoring and checking up on the elder.

Personal care, the most intensive and intimate caregiving task (Rankin 1990), includes helping the elderly person with a broad range of tasks such as bathing; dressing; walking around the house; eating; getting in and out of a bed or chair; grooming; taking medication; cutting toenails; and using the toilet.

Household activities are also often included in eldercare tasks. These labour-intensive services, which require regular time commitments, fall into two categories: housework and household maintenance. Housework includes: making the bed; doing laundry; preparing meals; cleaning up after meals; cleaning; washing floors; and vacuuming (Kaden and McDaniel 1990). Household maintenance includes tasks such as washing windows; putting up storm windows; painting; making minor repairs such as replacing worn electrical switches; and doing outdoor yard work such as gardening, lawn mowing and snow shovelling (Walker, Martin and Jones 1992).

Providing assistance with shopping, errands and transportation is a less intense form of support. These tasks are often intermittent, but are important in helping seniors remain in the community. Getting to necessary destinations is seen as an essential component of community living, and transportation is part of most comprehensive lists of eldercare as well (Keating 1991; Rankin 1990).

Assistance with financial management normally includes balancing chequebooks, paying bills or filing income tax returns (George 1987) and is considered to be an important supportive task to those who have never learned or are no longer able to manage their financial affairs.

Emotional support includes: maintaining social interaction; cheering up an individual who is depressed; providing reassurance; and validating attitudes or perceptions (George 1987). Providing opportunities for socialization, self-affirmation and self-actualization is seen as an important eldercare task as well (Cantor 1991).

Monitoring or checking up on seniors is considered important because it serves as a means for caregivers to check whether seniors have unmet needs or are being given poor quality services (Harlton, Keating and Fast 1997).

Throughout this book, we use a broad, inclusive definition of "eldercare" to describe the informal support that contributes to the independence of older Canadians (Dwyer and Secombe 1991).

Assistance versus care: Many of the tasks described above are services that people routinely do for one another throughout life. There is an ongoing debate about the circumstances under which the assistance that families and friends provide seniors (e.g., housework, transportation and other daily activities) becomes care (Harlton et al. 1997).

Perhaps the most common criterion used to distinguish routine assistance for seniors from care is whether the help provided compensates for losses in the elder's functional status. From this perspective, caregiving is viewed as the daily tending, support and monitoring of older adults who are incapacitated (Neysmith 1991) or who require compensation for severe losses of autonomy. Thus we consider "care to seniors" or "eldercare" to be assistance provided to someone age 65 and over with a long-term health problem or other disability. The assumption is that these seniors have chronic high needs and are of most concern to the practitioners and policy makers charged with caring for an aging population.

A second group of high needs seniors is those with an acute illness or other temporary problem. This is a group of current concern because of recent health service trends such as early discharge from hospital after surgery. Those experiencing a temporarily difficult time have high needs which are expected to be of short duration. A third group of seniors in receipt of assistance is those who share task responsibilities with others because of the ways responsibilities are delegated in families and households. A husband may always have had his meals prepared by his wife. A woman might not have a driver's license but relies on her spouse to take her to appointments, shopping, etc. People in these situations often become vulnerable when they lose the person who has provided those tasks. A fourth group of seniors may receive no assistance because they are able to meet their own needs, because they are isolated from caring resources or because they choose not to receive them.

Thus, at least three groups of seniors receive care or assistance: those with a long-term health problem; those experiencing a temporarily difficult time; and those who receive assistance because of the way things are done within the family structure. (There are also seniors who receive no assistance for various reasons: they are able to meet their own needs; they are isolated from caring resources; or they choose not to receive it.)

This book considers seniors in the first group—those with long-term health problems or disabilities—to be “care recipients.” Focusing on this group does not ignore or minimize the fact that seniors in the other two groups may also have high needs for assistance. However, the group with chronic health problems is an important focus of researchers, practitioners and policy makers. Chapter 2 compares these three groups to show how seniors who are receiving care because of a long-term health problem differ from those receiving assistance for other reasons.

Definition of terms for this study

Three questions were asked which determined whether a respondent had provided assistance:

- In the past 12 months did you individually or on behalf of an organization do any part of someone's meal preparation and clean-up, house cleaning, laundry and sewing, or house maintenance and outside work?
- In the past 12 months did you individually or on behalf of an organization do any part of someone's shopping for groceries or other necessities, provide transportation or do their banking or bill paying?
- In the past 12 months have you assisted anyone with a health or physical limitation by providing personal care such as assistance with bathing, toileting, care of toenails/fingernails, brushing teeth, shampooing and hair care or dressing?

Assistance: any of the following tasks provided to a senior because of a long-term health problem, because of a temporarily difficult time, or because of the way things are done in the senior's household:

Tasks: meal preparation and clean up; house cleaning, laundry and sewing; house maintenance and outside work; shopping for groceries or other necessities; transportation; banking or bill paying; personal care; emotional support; and/or checking up to make sure the senior is okay.

Care: assistance provided to a senior because of that senior's physical or long-term health limitation.

Informal caregiver: a friend or relative who provides care to a senior because of that senior's long-term health or physical limitation.

Care recipient: a person 65 and over who receives assistance with one or more tasks because of a long-term health or physical limitation.

Long-term condition: a condition that is expected to last more than six months and is either chronic or permanent.

In summary, the focus of this book is on informal care provided to Canadian seniors who are most at risk, those with a long-term health problem or physical limitation. Data for the book are a subset of the data available from the 1996 cycle of the General Social Survey, a national survey of all assistance provided by Canadians to other Canadians.

The General Social Survey

Background: The General Social Survey (GSS) gathers data on Canadian social trends through a single survey cycle on a different theme every year. The core content of each GSS is designed to monitor changes over time in the living conditions and well-being of Canadians and to provide immediate information on specific social policy issues of current or emerging interest. The range and periodicity of GSS provide data that are especially useful for the policy formulation and program development and evaluation required to operate more efficient government-funded programs.

The 1996 General Social Survey: The 1996 cycle of the GSS was the first to have informal caregiving as its core content, although some information on informal help was collected in the 1985 and 1990 surveys. Data for the 1996 GSS were collected monthly from February 1996 through December 1996. The target population was all persons aged 15 and over in private households in the 10 provinces. The sample population was selected using random digit dialing techniques. Respondents were interviewed by telephone with responses from 12,756 people. The response rate was 85.3%.

The purposes of the 1996 GSS were: to determine the nature of the help received and provided; to understand the dynamic between an individual's social network and the help received and provided; and to identify unmet needs and the reasons for the needs. The 1996 GSS focused on help given and received by respondents during temporarily difficult times or out of necessity because of long-term health or physical limitation. Information was collected from all respondents on the assistance they received from others and on the people who provided them with that assistance. Information was also collected from all respondents on the assistance they gave to others and on the recipients of that assistance.

Samples used in the book: In Chapter 2, the population of interest to us was all respondents 65 years of age and over, regardless of whether or not they received assistance. This sample provided the basis for the discussion of the different reasons for which seniors received assistance. For this chapter, the sample size was 5,952.

The population of interest to us in Chapters 3 and 4 was all respondents who provided care to a person 65 years of age and over because of the senior's long-term health or physical limitations. Information was collected from these respondents on the assistance they gave to seniors and about the people who received that assistance from them. This sample of 1,366 provided the basis for the detailed description of the nature and amount of care provided by informal caregivers to seniors. A sample size of 669 was used for the questions related to the labour force. While all respondents resided in private households, some seniors who received assistance from a respondent may have resided in an institution.

CHAPTER 2

SENIORS IN CONTEXT

Not only is Canada's population aging but Canadians are living longer today than in the past. What does this mean for the future? Will society be able to maintain and enhance the independence of this growing population of seniors?

Social support is a key element in the maintenance of independence (Chappell 1989). The services that people perform for one another are one aspect of social support. In the previous chapter, we defined "assistance" as services that are performed for others because household workloads are shared in certain ways or because the recipient is experiencing a temporarily difficult time. Individuals may get assistance when they do not know how to do an activity (such as driving a car); when a difficult time has rendered them temporarily unable to perform an activity that they have previously done (such as preparing meals if one is recently bereaved); or when the assistance reduces the work of having to carry out tasks on their own. In contrast, we have defined "care" as assistance to someone with a long-term health problem or other disability. Data provided in this chapter show that those receiving assistance because of a long-term health problem or other physical limitation (that is, those who receive care) see themselves as in poorer health than do those receiving assistance for other reasons.

The purpose of this chapter is to describe Canadian seniors who live in the community and receive care¹ because of a long-term health problem. We will do this by examining seniors in three different contexts: younger recipients of assistance; other seniors receiving assistance; and seniors in long-term health-related institutional settings.

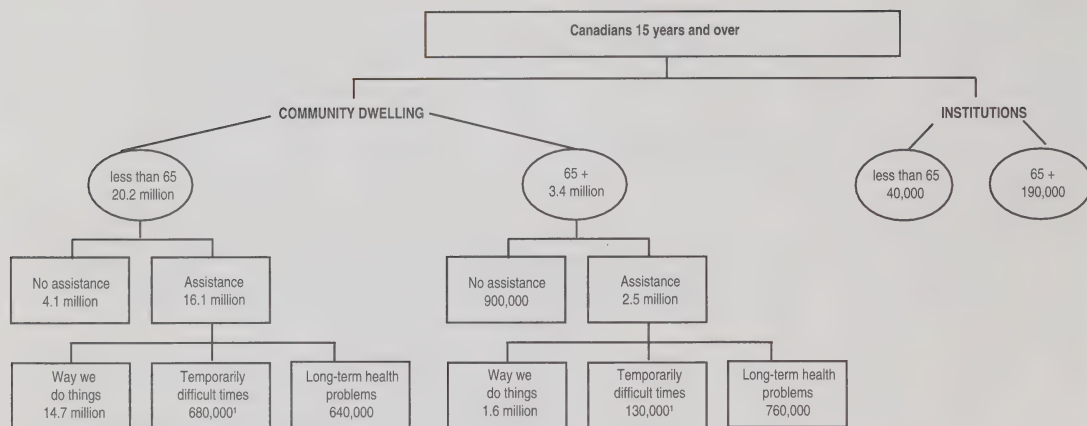
The first section of the chapter addresses the question of whether higher proportions of seniors than Canadians in other age groups receive assistance. Although there is an assumption that seniors are the predominant receivers of informal assistance, there has been relatively little comparison of seniors to younger Canadians. If seniors receive disproportionately high levels of assistance, then preparations in the formal and informal caregiving sectors will have to be made to cope with a growing population of older people. However, if seniors are not disproportionately high receivers, future caregiving needs should be considered within this context. This comparison adds to our understanding of the relative magnitude of senior's needs.

The second section of the chapter focuses on how seniors receiving assistance for different reasons compare to each other. Those receiving assistance because of a

¹ Some of the estimates in this chapter are based on small sample sizes and have high sampling variability. They are indicated with a superscripted numeral one (1) and should be used with caution.

Figure 2.1

Seniors in context



¹ Estimate subject to high sampling variability.

Sources: Statistics Canada, General Social Survey, 1996 and National Population Health Survey, 1994-95.

long term health problem; because of a temporarily difficult time; or because of the way things are done in households are compared. These comparisons help address the question of the extent to which seniors are heterogeneous in their needs. As part of this discussion, profiles of each group of seniors were developed. The proportion of seniors in each group who received assistance with various tasks was examined, and the likelihood of receiving care due to a long-term health problem or physical limitation was modeled. It is in this section of the chapter that the group of seniors who received care is identified. They are the focus of the remainder of the book. Only in this chapter are comparisons made between those receiving assistance and those receiving care.

In the final section of the chapter, community dwelling seniors receiving assistance for a long-term health problem are compared to seniors in long-term health-related institutional settings. Figure 2.1 illustrates the composition of the senior population in 1996.

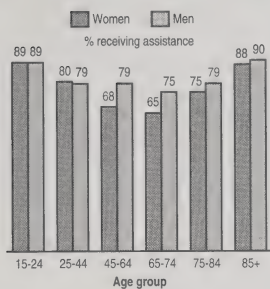
Data for this chapter come from two sources. The 1996 General Social Survey enabled us to examine the proportions of Canadians that resided in the community and received assistance and to determine the tasks with which they received assistance. The 1994-95 wave of the National Population Health Survey provided us with data on seniors living in institutional settings.

Receipt of assistance: Seniors compared to Canadians of all ages

In this section, we compared the proportion of seniors in the broad context of the population living in the community with the proportion of Canadians of all ages who reported that they received assistance from others during the past 12 months. The main question was whether the proportion of seniors receiving assistance was higher than that of younger Canadians.

Chart 2.1

Most Canadians receive assistance



Source: Statistics Canada, *General Social Survey, 1996*.

Respondents were assumed to be in receipt of assistance if someone had done any task for them in the past 12 months in at least one of the following groups of activities, as outlined in Chapter 1: household tasks (including meal preparation and clean-up, housecleaning, laundry and sewing, house maintenance and outside work); errands (including shopping for groceries or other necessities, providing transportation, and doing banking or bill paying); and personal care (including assistance with bathing, toileting, dressing, etc.). Emotional support and checking up were excluded here (Chart 2.1).

Results revealed that the vast majority of Canadians of all ages received some type of assistance with their everyday activities. Almost 80% of non-seniors (over 16 million people) and 73% of seniors (almost 2.5 million people) who still lived in the community received assistance.

It should be kept in mind, however, that while most Canadians received assistance, the reasons for receiving it differed considerably. For example, just 3% of non-seniors were receiving care because of a long-term health problem or physical limitation compared with over 20% of seniors.

There were also differences across age groups in the proportions receiving assistance. Among seniors, the highest proportion receiving assistance were those 85 and over (89%). These older seniors are often seen as most at risk for needing supportive care. Findings showed that much higher proportions of these seniors receive assistance than do seniors aged 75 to 84 (77%) or 65 to 74 (70%).

Of note is the finding that the same proportion of people aged 15 to 24 (89%) received assistance, as did the oldest seniors. However, the oldest seniors were more likely to be receiving assistance because they were in need for health-related reasons. In contrast, the youngest people were more likely receiving assistance because they were not yet financially or emotionally independent of their parents. Seven out of every 10 15- to 24-year-olds receiving assistance were living at home with their parents.

While most Canadians received assistance, substantial minorities in all age categories reported receiving no assistance from others. Twenty percent of people under 65 years of age and 26% of seniors received no assistance. Many of these were likely capable of performing necessary tasks for themselves. However, there may be some vulnerability among those who live alone and do not have immediate access to others for help. This seems especially likely for older people. While about one-third of non-seniors who were without assistance lived alone, over half of seniors receiving no assistance were living alone.

In summary, when it comes to receiving assistance from others, similar proportions of seniors and non-seniors received assistance. And, across age groups, only a minority reported that they received no assistance. This suggests that, in terms of receiving assistance with various tasks, seniors were not the disproportionately high recipients of assistance that is often assumed.

Nonetheless, different reasons for receiving assistance suggest that resources required to care for the young and the old may be substantially different. Similar to the comparison between seniors and non-seniors, comparisons among groups of seniors highlight their differences both in the reasons for receiving assistance and in the types of tasks with which help was received.

Receipt of assistance: Seniors compared to seniors

In Chapter 1, we pointed out the difference between assistance and care for seniors. Data from the General Social Survey showed that most Canadians, seniors included, received assistance from others. However, much of the concern about the aging of the Canadian population is focused on needs of a subgroup of those receiving assistance: seniors with a long-term health or physical limitation who require care.

This section places seniors receiving care in the context of other seniors living in the community. This comparison can help develop a better understanding of the magnitude and characteristics of the group of seniors receiving care, and whether or not they differ from other seniors receiving assistance for other reasons.

To conduct the analysis of how seniors receiving care differed from other seniors residing in the community, seniors were classified into three groups based on the reasons for receiving assistance: because of the way tasks were shared in their household; because of a temporarily difficult time; or because of a long-term health problem or physical limitation. A fourth group of seniors comprised people who received no assistance with their daily activities.

As mentioned earlier, the majority of Canadian seniors (73%) received assistance. More than 1.6 million seniors (47%) received assistance because of the way things were done in their households, 128,000 (4%) because of a temporarily difficult time, and more than three-quarters of a million (22%) because of a long-term health problem. It is this last group that we have defined as being in receipt of care. Hence, although the majority of seniors received assistance, the minority received care. This smaller group is the focus of the remainder of the book. Only in this chapter are comparisons made between those receiving assistance and those receiving care (Chart 2.2).

The largest group of seniors receiving assistance (47%) got help because it was “the way they do things” within their home. Higher proportions of men (57%) than women (40%) received help for this reason. Typically, there is a gendered division of labour in households: the wife may do all of the cooking while the husband may do all of the yard work. Because tasks done by women and men in the current cohort of seniors are especially segregated, if a partner dies, the remaining spouse may not have the skills to do household activities that were the responsibility of the other partner (Frederick 1995). This suggests that while members of this group are functioning with routine assistance provided in the home, changes that could result in their needs being unmet, such as the loss of a spouse, may make them vulnerable.

Only 4% of seniors were receiving assistance because they were experiencing a temporarily difficult time, and most of those had a short-term illness or minor injury. This group may be small because many of the health problems associated with old age are chronic rather than acute.

A third group was receiving assistance because of a long-term health problem or physical limitation. Twenty-two percent of Canadian seniors fell into this group—more women (26%) than men (17%). Increasing numbers of older Canadians with longer life expectancy, as well as changes in the health care system such as shorter hospital stays and greater use of outpatient treatment, have put the assistance needed by people with poor health in the forefront of societal concerns. Although this group is a minority among seniors, their care needs are high.

Reasons for receiving assistance

The way they do things: the way household tasks are routinely shared.

Temporarily difficult times: a short-term condition lasting or expected to last less than six months, including: the birth of a child; short-term health problems; moving or changing jobs; financial problems; an accident; or the death of someone close.

Long-term health or physical limitation: any chronic or permanent condition lasting or expected to last more than six months.

Measuring assistance

- 1) Respondents who received assistance with at least one task as a result of a long-term health problem or physical limitation were classified as receiving care because of a long-term health problem regardless of other reasons for which they may have received assistance.
- 2) Respondents who received assistance with at least one task as a result of a temporarily difficult time and did not receive care as a result of a long-term health problem or physical limitation were classified as receiving assistance because of a temporarily difficult time regardless of other reasons for which they may have received assistance.
- 3) Respondents who received assistance with at least one task as a result of "the way they do things" and did not receive care as a result of a long-term health problem or physical limitation or assistance for a temporarily difficult time were classified as receiving assistance because of "the way they do things."
- 4) A respondent receiving no assistance was classified as receiving no assistance.

A fourth group, comprising 27% of Canadian seniors with slightly higher proportions of women (30%) than men (23%), reported that they had received no assistance. Although this group may include the most independent seniors, it may also include seniors with unmet care needs. Many of these people live alone and may lack resources to which they can turn for assistance.

While the vast majority of seniors received assistance in carrying out their daily activities, the reasons for receiving it varied. To address the question of how those receiving care might differ from those receiving other assistance or no assistance, profiles of members of each group were developed. These help to place the seniors receiving care for their long-term health problems into the context of all seniors residing in the community. The profiles were based on demographic characteristics (age, gender, marital status, urban/rural residence and perceived health) of all four groups of seniors.

Characteristics of seniors receiving assistance

Age/degree of frailty: Seniors receiving care were older on average (77 years of age) than the seniors in the other groups. This finding was expected since care is associated with failing health, and health tends to deteriorate with age. For people getting assistance because of a temporarily difficult time, the mean age was 73 years; for those receiving assistance because of "the way they do things" and for those receiving no assistance, it was 72 years.

Gender: Higher proportions of men (57%) received assistance because of “the way they do things” than women (40%). However, a larger proportion of women received care because of long-term health or physical limitation (26% versus 17%) and assistance because of temporarily difficult times (5% versus 3%). However, higher proportions of women than men received no assistance (30% versus 23%), which suggests that women may be at greater risk of having unmet needs (Chart 2.2).

Marital status: Married seniors were more likely to receive assistance because of “the way they do things” (63%, compared to just 25% of unmarried seniors). Unmarried seniors were most likely to receive no assistance (40%). As well, one-third of unmarried seniors (31%) received assistance for a long-term health problem, compared to just 16% of married seniors. Widows comprise the largest category of unmarried seniors in both groups, although almost one-third of the unmarried seniors receiving no assistance were divorced or single. Unmarried seniors may be among the most vulnerable to social isolation and at greatest risk for having unmet needs for care because they are most likely to be without strong family ties (Chart 2.3).

Urban/rural residence: There was no difference in the proportions of urban dwellers and rural dwellers across the four groups. Approximately 80% of seniors in all four groups lived in urban areas.

Perceived health: Another way to differentiate the groups of seniors is by health status. One such measure is seniors’ perception of their health. Respondents were asked: “Compared to other people your age, how would you describe your state of health?”

The largest proportion of recipients of care for long-term health problems reported their health to be fair to poor, suggesting that their perceived health status was congruent with their receipt of care. Across the groups, the largest percentage of people who perceived their health to be fair to poor were those receiving care because of long-term health problems. Most people getting assistance because of a temporarily difficult time perceived their health to be very good to excellent, while the remaining people in this group were evenly divided between good and fair to poor health. It can be speculated that these people, while experiencing a short-term ailment, were not likely to report poor health because they expected a full recovery from their injury, operation or condition.

Interestingly, seniors receiving assistance because of “the way they do things” and those getting no assistance had similar levels of perceived health. The majority of seniors in both groups reported being in excellent to good health. However, the seniors who were without assistance were more likely to be unmarried and, therefore, may be at greater risk of having unmet needs if they experience a reduction in health status (Chart 2.4).

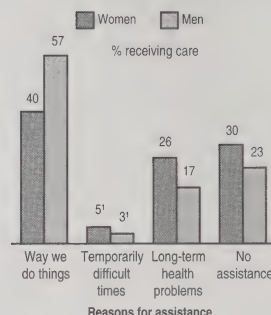
In summary, according to the descriptive statistics, the seniors were a very heterogeneous group. While most seniors did receive assistance, reasons for the assistance varied, as did the demographic characteristics of the seniors composing each group.

The most distinct group of seniors was the one that reported receiving assistance for long-term health problems. While a large percentage of these seniors were women, the group also tended to be older than the other seniors and in poorer health. Most were unmarried.

The group that received assistance because they were experiencing a temporarily difficult time also included a high proportion of women, but they were younger. They perceived

Chart 2.2

A minority of senior women and men receive care

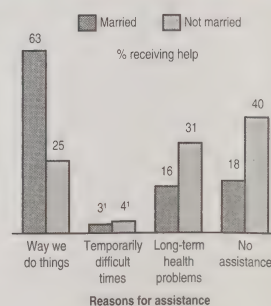


¹ Estimate subject to high sampling variability.

Source: Statistics Canada, General Social Survey, 1996.

Chart 2.3

Married seniors more likely to receive help

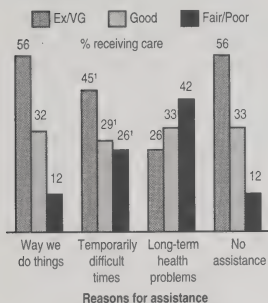


¹ Estimate subject to high sampling variability.

Source: Statistics Canada, General Social Survey, 1996.

Chart 2.4

Seniors receiving care were in poorer health



¹ Estimate subject to high sampling variability.

Source: Statistics Canada, General Social Survey, 1996.

themselves to be in better health than those receiving care, but not as healthy as those receiving assistance because of “the way they do things” or those receiving no assistance.

Those who received assistance because of “the way they do things” were also a distinct group. They had the largest proportion of married seniors and also tended to report high levels of perceived health. Interestingly, this group most resembled the seniors who did not get any assistance with their daily activities. While those without assistance were predominantly women there were similarities across age and health.

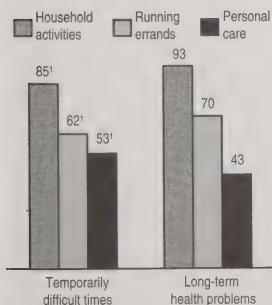
Receipt of assistance: Various tasks

Findings presented in the previous section show that people receiving care for a long-term health problem differed on demographic characteristics from those receiving assistance for other reasons as well as from those receiving no assistance. These groups can also be compared according to the specific tasks with which they received assistance. Investigating this is important in order to understand not only who receives assistance but also how the nature of this assistance differs across the groups of seniors. To address the question of how the groups differ in the tasks with which they received assistance, the tasks were grouped into household activities (meal preparation and clean up, house cleaning, laundry and sewing, house maintenance and outside work); errands (shopping for groceries or other necessities, providing transportation, and doing banking and bill paying); and personal care. For all groups, we calculated the proportions of seniors who received help with each set of tasks (Chart 2.5).

There was virtually no difference in getting help with household tasks between the proportions of care recipients with long-term health problems (93%) and recipients of assistance because of “the way they do things” (92%). A smaller proportion of seniors having a temporarily difficult time got help with these tasks (85%). Similarly, there was no difference between the proportions of seniors receiving care for long-term health problems who got assistance running their errands (70%) and those whose assistance was because of “the way they do things” (71%). A somewhat smaller proportion of seniors experiencing a temporarily difficult time (62%) got assistance with errands. The smaller percentage of people having a temporarily difficult time receiving assistance with household tasks and errands may be explained by the fact that many of these tasks, with the exception of meal preparation, could be postponed until the person recovered. These people may also be less likely to call on others for help with these tasks if they anticipate their needs to be short term.

Chart 2.5

Seniors least likely to receive help with personal care



¹ Estimate subject to high sampling variability.

Source: Statistics Canada, General Social Survey, 1996.

People are not likely to seek assistance with their personal care unless absolutely necessary. Therefore, it was not unexpected that smaller proportions of seniors received assistance with their bathing and dressing than with the other sets of tasks. Fifty-three percent of seniors experiencing a temporarily difficult time received assistance with personal care, compared with only 43% of those with a long-term health problem. This finding was surprising as one would expect more people with long-term health problems to be getting help with these tasks. It may be that seniors having a temporarily difficult time are experiencing acute and intense health problems such as recovering from surgery. Such difficulties may require high levels of personal care, but only for a short time.

To summarize, the descriptive statistics on tasks indicated that seniors were not nearly as heterogeneous in receipt of assistance as they were in terms of their demographic profiles. Rather, most seniors received assistance with a variety of household tasks. The reason for receiving help with the task—not the nature of the task itself—distinguished “assistance” from “care.”

Predictors of receipt of care

The next step in contextualizing care to seniors with long-term health problems was to determine who was most at risk of requiring care. In order to move beyond providing a description, we modelled the likelihood of receiving care because of a long-term health problem or physical limitation and estimated the model using logistic regression analysis. The dependent variable—receipt of care for long-term health problems—took the value of 1 for people who received care and 0 for those who did not. The coefficients in the regression equation were expressed in odds ratios, which measured the effect of the independent variable on the relative likelihood of receiving care, controlling for the other variables in the equation. Analyses were done separately for women and men, since gender differences in the predictors of receipt of care were expected (Table 2.1).

Of all the variables included in the model, health had the strongest impact on the probability of receiving care. Compared to women who perceived their health to be excellent, women in very good health were two and half times more likely to receive care for their long-term health problems. However, those who perceived their health to be poor were 42 times as likely to get care as women who perceived their health to be excellent. The same pattern emerged for men although the effects were even stronger. Men who rated their health as poor were 85 times as likely to receive care as men who rated their health as excellent. The importance of health was as expected. Nonetheless, the magnitude of the effect was quite striking.

When we controlled for other factors, the effect of age was significant for women and men. Compared to women 65 to 74 years of age, women 75 to 84 (odds ratio 2.2) and 85 years and over (odds ratio 7.4) were more likely to receive care. The same pattern emerged for men but the effects were not quite as strong. Men 75 to 84 years of age were twice as likely and men 85 years and over more than five times as likely to receive care compared to the youngest seniors. This finding is not attributable to perceived health, which is controlled for in the model. With age, seniors may become less able to do the tasks they once could do, such as lifting groceries or vacuuming, and therefore require care.

Marital status also revealed gender differences. Widowed men were twice as likely to receive care because of long-term health problems as married men. There are several plausible explanations for this finding. Married men may not report receiving care from their wives, especially if they were getting assistance with particular tasks before the help was needed because of their failing health. Another possibility is that caregivers may be more willing to step in and care for persons who are widowed and on their own. Some widowed men may not have the skills to perform certain tasks, such as cooking and laundry, so others must help. There was no difference in the likelihood of divorced or single men receiving care compared to married men. Possibly these men have been on their own longer and have developed the skills to carry out day-to-day tasks on their own.

Table 2.1
Health most important predictor of receipt of care

Independent Variables	Odds Ratio	
	Women	Men
Category		
Perceived health		
Excellent	1.0	1.0
Very good	2.5***	2.2**
Good	4.1***	4.4***
Fair	9.5***	15.3***
Poor	42.1***	84.7***
Age		
65-74	1.0	1.0
75-84	2.2***	2.1***
85+	7.4***	5.3***
Marital status		
Married	1.0	1.0
Divorced	1.6*	0.6
Widowed	2.0***	2.1***
Single	1.8**	1.4
Place of residence		
Urban	1.0	1.0
Rural	1.5*	1.3*

* Statistically significant at the .05 level.

** Statistically significant at the .01 level.

*** Statistically significant at the .001 level.

Source: General Social Survey, 1996.

Widowed (odds ratio 2.0), divorced (odds ratio 1.6) and single (odds ratio 1.8) women were also more likely to receive care than married women. Again, people may be more willing to step in and assist a person who is on her own. This may be true for widowed women who may need assistance with tasks that their spouse previously performed for them, such as transportation and banking. The finding that divorced and single women were more likely to receive care than married women while there was no difference for men may be explained by the differences in social networks of women and men. When a spouse is available, there is an assumption that care will be provided. Thus, married women who do not receive care from their husbands may not have comfortable access to other family members and friends who might provide support. In contrast, unmarried women are likely to have access to this broader support network. Men tend to have smaller support networks and may be less likely to have these friendship relationships available.

There is an assumption that seniors in rural areas of the country are more likely than those living in cities to have extensive, closely knit, informal networks and a stronger sense of community. Both of these imply there are more caregivers available to provide support. Thus one would expect that rural dwellers would be more likely than urban dwellers to receive assistance when their health fails, and the data supported this. For both women and men, when all other factors were controlled for, people living in rural areas of Canada were more likely to receive care for long-term health problems than were those in urban areas.

Who typically receives care? For both women and men, those receiving care were likely to perceive their health as poor, to be widowed, to be the oldest elderly, and to reside in rural areas. What these findings suggest is that health status rather than age is the key in determining the care needs of an aging population. Therefore, it should not be assumed that because Canada faces an aging population there will be a needy senior population that requires a great deal of care. The findings indicate that if the next cohort of seniors is healthier, care needs may not escalate dramatically with population aging as predicted.

Receipt of care: Community versus institutionalized seniors

GSS findings have established that seniors receiving care because of long-term health problems were the oldest and sickest in the community population. But how do they compare to those who reside in health care-related institutions? Since seniors in both groups received care because of a long-term health problem, do they differ in their demographic profiles or in their receipt of formal versus informal care?

This question was addressed by comparing data from the 1996 GSS on community-dwelling seniors receiving care because of their long-term health problems with data from the National Population Health Survey (NPHS) on seniors residing in institutions in 1995.² Initiated in 1994, the NPHS is a longitudinal survey that is scheduled to last 20 years, with data collected every two years. It is designed to collect information on the health status and utilization of the health care system by Canadians residing both in the community and in long-term health-related institutional settings.

The most significant difference between the two populations of seniors was the sheer numbers. While almost three-quarters of a million community-dwelling seniors received care for their long-term health problems, only 186,500 seniors lived in health-care-related institutions.

² The 1995 data were the most recent National Population Health Survey data available at the time this publication went to press.

Although seniors in institutions (mean age of 84 years) were older than those who received care at home (mean age of 77 years), both groups were predominantly female. Two-thirds (67%) of the community-dwelling seniors and nearly three-quarters (73%) of the residents of institutions were women. However, there were differences between the groups (Charts 2.6).

While nearly half (48%) of community seniors getting care were widowed, this proportion increased to 65% of seniors living in institutions. However, these proportions do not illustrate the strong gender differences in marital status between community-dwelling and institutionalized seniors. Among those in institutions, 75% of female residents were widowed while male residents were more evenly divided between being married and widowed. Among those in the community, about 60% of women were widowed compared with just 20% of men (Chart 2.7).

The health status of these two groups also differed. More than half of the residents of institutions rated their health as fair to poor while very few considered their health to be excellent. In contrast, less than 40% of the community recipients rated their health as fair to poor. A higher proportion of community-dwelling seniors receiving care rated their health as excellent or very good than did residents of institutions (Chart 2.8).

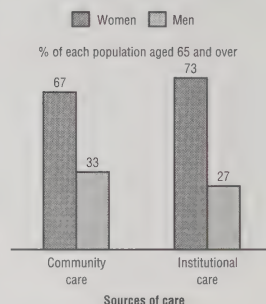
Another way to compare the health of institutionalized versus community-dwelling seniors is in terms of their cognitive abilities. According to the NPHS, Alzheimer's disease and other dementias among those 65 years and over were more prevalent in health care institutions than in the community. One in three residents of institutions had been diagnosed with these diseases. In the same age group living in the community, the numbers were too low to be accurately estimated. The substantially smaller proportions of community-dwelling seniors experiencing these ailments can be partly explained by the fact that many seniors are likely to have dementia for several years before it is diagnosed. The numbers of community-dwelling seniors suffering from this condition, therefore, is likely to be undercounted. However, this cannot negate the fact that high proportions of residents of institutions are suffering from Alzheimer's disease or other dementias (Statistics Canada 1995).

The two groups of seniors also varied in the source of their care. For community-dwelling seniors who received assistance, 90% of assistance with household tasks and errands was provided by informal caregivers. Only 10% of help with these tasks was provided formally by government or non-government organizations or a caregiver paid by the senior. The distinction was not quite as clear for personal care, as about two-thirds of these intimate tasks were provided by family and friends. That approximately 30% of personal care was provided formally might be explained by the discomfort felt by many people with entrusting their intimate needs to family members such as adult children. In contrast, institutionalized seniors received the majority of their assistance from formal sources.

In summary, seniors in the community differ in some important ways from seniors in residential care settings. While both populations were predominantly female, the institutionalized population was older and in poorer health than the community population. This finding was further confirmed after comparing the cognitive ability of the two groups. The analysis suggested that with increased age and declining health status (especially cognitive health), seniors who still lived at home would be more likely to need institutionalized care. Reducing care needs by maintaining a healthy senior population may be difficult to accomplish if the vast majority of severe health problems are cognitive, unless a cure for dementia is found.

Chart 2.6

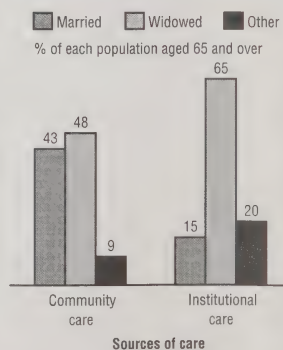
Similar proportions of women and men received community and institutional care



Source: Statistics Canada, National Population Health Survey, 1994-95.

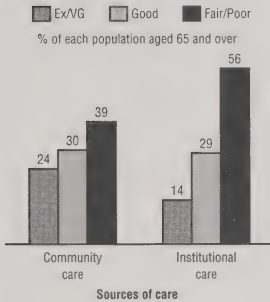
Chart 2.7

Higher proportions of widowed in institutional care



Source: Statistics Canada, National Population Health Survey, 1994-95.

Chart 2.8

**Institutionalized seniors
in poorer health**

Source: Statistics Canada, *National Population Health Survey, 1994-95*.

Institutionalized seniors were also more likely to be receiving care from formal sources. A major difference between the two groups of care recipients may be that the care needed by the institutionalized population exceeded that which informal sources were able to give (Shapiro 1995).

While the community population was not as old or as sick as the group in institutions, the substantial numbers of community-dwelling people who receive care for their long-term health problems pose potential social problems. These people have high needs and are likely to require care for the remainder of their lives. If the amount of residential, continuing-care beds remains stable or even decreases, and if the needs of these seniors move beyond what can be provided in a community setting, there may be no place for these seniors in institutional care. Therefore, increased pressure is likely to be placed on the informal and formal community care sectors.

Conclusion

At the time of the 1996 General Social Survey, about 15% of Canada's community-dwelling population 15 years of age and older—3.4 million people—were seniors. Within this population, as in the non-senior population, a large majority of individuals received assistance to carry out their everyday activities. However, there was a smaller, distinct group that received care because of their long-term health problems. These were the seniors who had the highest needs for care from both formal and informal sources in the community population. They are also the group of most concern to policy makers who must decide how best to provide support to seniors and their caregivers.

It is important to remember that health status rather than age was the most important predictor of receipt of care. This suggests that a senior population that is in good health may not fulfill the predicted escalation of care needs, even in an aging society. However, as hospital reductions and restructuring in the health care sector continue, seniors are going to have to continue to rely on non-institutionalized care, especially informal assistance from family and friends. The following chapters focus on these issues, as informal caregiving to seniors is further explored.

CHAPTER 3

CONTENT: PROFILE OF CAREGIVERS AND RECIPIENTS

In this chapter we address two key questions: who are the informal caregivers to seniors with long-term health problems, and what services do they provide to these seniors? This profile reveals the breadth of Canadians' involvement in providing informal care to seniors. Detailed analyses of the types and number of services they provide to seniors refine the portrait. Organized into three sections, this chapter opens with a review of the current state of knowledge of eldercare providers and services. The second section, using data from the 1996 General Social Survey (GSS) of Social and Community Support, describes both the caregivers and the recipients of their care. The concluding section examines the predictors of the amount of time caregivers spend in various caregiving activities.

Eldercare providers and services: A review of the current literature

Not everyone who has informal relationships with a senior is equally likely to be involved in the provision of eldercare. A number of conditions influence the ability and willingness of a caregiver to provide help. Specifically, there is evidence to suggest that three sets of factors are influential in determining who will be eldercare givers: characteristics of the caregiver including demands that compete with an individual's ability to provide care; characteristics of the care recipient; and characteristics of the caregiver–care recipient dyad.

Characteristics of the caregiver

A number of personal characteristics of informal caregivers have been identified in previous research into the question of who provides informal care. Three of these—gender, age and education—appear to be particularly salient in determining one's status as a caregiver.

Gender: Consistent with other types of domestic responsibilities, participation in care for the elderly is affected by gender. Women are the predominant caregivers of older dependent family members. Reports suggest that almost three-quarters of caregivers are female (Penrod *et al.*, Tennstedt, Crawford and McKinlay 1993). At some point in their lives, in their roles as mothers, wives, daughters, daughters-in-law, or as friends and neighbours, most women will provide care to the seniors in their lives. (Dowler, Jordan-Simpson and Adams 1992).

The most common explanation for the differences between women and men's involvement in informal caregiving concerns the social construction of gender roles. Women's expectations, behaviours and experiences of caregiving are often shaped by social ideologies that define caregiving tasks as "normal" female responsibilities. In contrast, the widely accepted responsibilities for men are in the paid labour force rather than in nurturing roles. Consequently, men may be less motivated to provide eldercare than are women because of their differing socialization, moral beliefs, sense of obligation, or satisfactory options for paid employment (Walker, Pratt and Eddy 1995).

Social ideologies may also prompt women and men to define their caregiving responsibilities in different ways. For example, women may not consider tasks such as meal preparation, laundry and housecleaning as caregiving because these activities are part of their normal domestic role (Walker et al. 1995). On the other hand, household chores are not normal responsibilities for many men so when they must complete these tasks for an elderly person, men consider themselves to be providing informal care.

The role of gender in predicting the likelihood of being an informal caregiver is less clear when considered in conjunction with other factors. Gorey, Rice and Brice (1992) found that gender is not significantly related to caregiving in samples of women and men who are employed. Reports that similar proportions of female and male caregivers exist in single-generation households also contradict the notion of an informal system of eldercare that is dominated by women (Noelker and Wallace 1985).

In a Manitoba study of gender differences in helping networks of seniors, Chappell (1989) found that for seniors with functional disabilities there were few gender differences among caregivers. Chappell suggests that, in the face of serious threats to health, societal expectations about women as the main caregivers dissipate.

Age: An individual's age is thought to be another important characteristic in determining potential to become a caregiver. The age of primary caregivers cited in previous studies spans at least 30 years (beginning around age 52 to age 84). Closer examination of this group reveals that a large proportion of female caregivers are 65 and over, and, with an average age of 73 years, married men represent the oldest category of caregivers (Stone, Cafferata, and Sangl 1987). Clearly, elderly persons are not only recipients of care, but are also key care-providers.

Research findings point to three typical caregiving patterns based on age:

- the youngest age categories comprise adult children who provide assistance to a dependent parent;
- among spouse caregivers, women are younger than men; and
- women caregivers with children of their own are older than are men in the same situation (Barnes, Given, and Given 1992; Walker et al. 1995).

Education: One hypothesis is that the higher an individual's educational level, the less time he or she will have to commit to caregiving. This hypothesis is based on the assumption that highly educated people have a greater likelihood of being employed and a greater commitment to full-time work (Boaz and Muller 1992). Another common assumption is that individuals with lower levels of education are less likely to consider their employment as a career. Thus, they have less stake in continuing their employment and are more likely to leave the labour force to become caregivers (Stone and Short 1990).

The results of recent studies do not fully support these expectations and assumptions. For example, Thornton, White-Means and Choi (1993) found that social class was not a significant predictor of the structure of caregiving networks.

Marital status: The majority of primary caregivers are married. For some caregivers, marriage may enhance their ability to provide care. For example, individuals whose spouse provides them with financial support may be more able to provide care than someone who does not have access to such support (Boaz and Muller 1992). However, others argue that those who are married have commitments to their spouse that compete with the demands of caregiving. Findings are that adult children who are married are less likely to provide help to parents than those who are single (Stoller 1983).

Employment status: Evidence of the relationship between a caregiver's employment status and level of involvement in the care of an elderly family member is inconclusive. While some researchers have found that the majority of caregivers are employed full time (Gorey et al. 1992), others have found that working outside the home decreases the probability of being a caregiver (Boaz and Muller 1991). Employed caregivers are usually secondary caregivers (Gorey et al. 1992).

Interactions with gender may account for some of the inconsistencies in these findings. Employed daughters give the same amount of care as do their non-employed counterparts (Walker et al. 1995), but employed sons provide less help to an elderly parent than non-employed sons (Noelker and Wallace 1985).

Presence of young children: Another factor that may influence ability to provide informal care to a frail senior is whether the caregiver is also caring for children. A common argument in the caregiving literature is that people with young children may reduce the time they spend assisting elderly relatives in order to meet the demands of their parental roles. However, recent research suggests that raising children does not increase the likelihood that a caregiver will opt out of providing care (Boaz and Muller 1991). In a random sample from telephone directories in four midwestern states, 15% of respondents were caring for their own children and dependent parents (Nichols and Junk 1997).

Number of people cared for: It has been argued that caring for more than one person requiring assistance negatively influences the time that a caregiver can allocate to each care recipient. The extent to which caring for more than one person becomes a competing demand depends upon the number of different tasks that a caregiver must perform, as well as the amount and nature of assistance that is required by each care recipient (Boaz and Muller 1992).

Women may be most at risk of having several people to whom they are providing care. Women tend to have wider social networks than do men and may be more likely to help non-kin than are men (Campbell and Lee 1992).

Characteristics of the care recipient

A number of personal characteristics of dependent seniors may affect who will provide them with support, as well as the level of informal care they will receive from that person. However, much of the existing literature emphasizes the impact on the care provider of providing care. As a result, relatively little is known about the relationship between the potential for being a caregiver and the demographic characteristics of the frail senior. Two characteristics of care recipients indirectly identified in previous research—namely, recipients' gender and age—may be particularly influential in determining the caregiver's status.

Gender: Elderly Canadian women are more likely than are elderly men to be recipients of informal care (Kaden and McDaniel 1990). Some U.S. studies note that a sizeable majority—from 70% to over 90%—of parents who are cared for by their adult children are widowed women (Barnes et al. 1992; Sanborn and Bould 1991). In contrast, men account for more than three-quarters of the frail senior population who are cared for by a spouse.

The main reason for the strong presence of women in the care-recipient population is that women have a longer life expectancy than do men. As a result, elderly women have a greater likelihood of suffering deteriorating health and long-term disability that requires the assistance of family and friends for longer periods of time (Wilkins and Adams 1983).

Age: Decreases in physical and/or cognitive functioning typically occur as people grow older. Hence, a care recipient's age is a key predictor of assistance with certain tasks from an informal caregiver. Chappell (1991) found that there is a direct relationship between age and receipt of informal care among Canadian seniors.

In a national study of long-term care conducted in the United States, Stone et al. (1987) found that one-fifth of all care recipients were 85 years of age and over, with an average age of 78. Others report that the median age of female care recipients is about 84 years (Walker, Pratt, Shin and Jones 1989).

Characteristics of the caregiver–care recipient dyad

While characteristics of elders and their caregivers provide some insight into patterns of informal care, they explain only part of the total caregiving picture. In order to generate a more thorough understanding of informal care, we must also consider the dyad of caregiver and care recipient (Abel 1990; Stone 1991).

Characteristics that define the caregiver–care recipient dyad include the type of relationship of caregiver to care recipient, geographic proximity of care provider and receiver, the quality of the relationship between caregiver and care recipient, the number of years of caregiving, and the status (primary versus non-primary) of the caregiver.

Type of relationship of caregiver to care recipient: Relationships between caregiver and receiver have been the central focus in previous research and are defined in terms of two main categories: kin and non-kin. In describing kin relationships, existing studies distinguish between immediate family members of the care recipient such as spouses, children, siblings and in-laws and a diverse group of more distant kin including aunts, uncles, nieces, nephews and cousins. Non-kin typically are friends and neighbours of the frail elder (Tennstedt et al. 1993; Thornton et al. 1993).

The absence of comprehensive comparisons among these groups of informal caregivers means that research findings about caregiving relationships are inconclusive. For example, while some suggest that spouses typically serve as the only informal caregivers to their spouse (Tennstedt et al. 1993), others have reported the primary role of adult children as caregivers (Green 1991; Penrod et al. 1995). Siblings are seen as backup caregivers who step in when care recipients do not have a spouse or adult child to assist them (Cicirelli, Coward, and Dyer 1992). The lack of assistance provided by siblings has been explained in terms of generational and health status factors. Since they are of the same generation and, hence, of a similar age to the recipient, siblings' ability to provide care may be limited by their own functional capacity.

Some have argued that immediate family members provide most care and that more distant relatives and non-kin serve in caregiving roles only under very special circumstances such as the absence or unavailability of children (Penrod et al. 1995; Thornton et al. 1993). The assumption that non-kin have smaller roles in assisting the elderly has led to a preoccupation with family caregivers and a corresponding neglect of the contribution made by non-kin care providers.

Geographic proximity of caregiver to care recipient: Geographic proximity is a salient predictor of involvement in caregiving. Regardless of their relationship to the recipient, caregivers who live with care recipients provide significantly more hours of help, and perform more diverse caregiving tasks, than those who live apart from the recipients (Boaz and Muller 1992; Penrod et al. 1995).

Family caregivers who live with a frail senior are more likely to be spouses than adult children. However, as their age and frailty increases, seniors are more likely to live in close proximity to an adult child, although daughters are less likely to reside with care recipients than are sons. In contrast, siblings and extended family members who have taken on a caregiving role are more likely to live with their elderly relative (Sanborn and Bould 1991; Tennstedt et al. 1993).

Non-kin caregivers typically do not live with care recipients (Tennstedt et al. 1993). However, intimate friendships are important to the elderly—in particular when such friends live near to them and are able to be in frequent contact. The assistance of friends and neighbours is especially important to care recipients who do not live with a spouse or adult children.

Quality of relationship between caregiver and care recipient: The care provided to a frail elder is influenced by the quality of the relationship between the caregiver and care recipient. When interpersonal conflict exists between a parent and child in the early years of their relationship, tension follows in the caregiving relationship between adult child and frail elder parent in later years. Such tension may lessen the extent to which a potential adult child caregiver is willing to provide assistance to her or his dependent parent. Equally, this tension can make caregiving to a spouse especially difficult. Further, a high obligation to provide care may lead to reduced feelings of intimacy (Walker, Pratt, Shin and Jones 1990).

Primary caregiver status: Most caregiving studies focus on an individual who is defined as the principal or primary caregiver. In a national study of caregivers in the United States, Stone et al. (1987) reported that approximately 70% of the caregiving population is made up of primary caregivers. The primary caregivers of elderly family members are most often spouses, followed by adult children (Brody 1981). Some studies suggest that these primary caregivers are mainly women who care for their husbands and daughters and daughters-in-law who provide assistance to their elderly dependent parents (Cantor 1983). Sons typically do not perform a primary caregiving function but serve in secondary caregiving roles (Stone et al. 1987). Little is known about whether primary and secondary caregivers provide different types of tasks in their caregiving roles.

Length of time caregiving: Caregiving to a frail senior often spans a period of several years. Some studies suggest that about 44% of caregivers provide assistance to a dependent person for one to five years, and one-fifth provide care for five years or more (Stone et al., 1987). The results of an analysis of the 1986 General Social Survey show that a woman will spend an average of 18 years providing some form of care for her dependent parents (Dowler et al. 1992).

Summary of descriptors: Prior research points to gender and age as the salient personal characteristics of both caregivers and care recipients. Caregivers are most likely to be caring for senior women, who are among the oldest of Canadians. However, there may be other salient characteristics that have yet to be investigated.

Caregivers may have competing demands including marriage, employment, young children, or others to care for; however, it is not clear how these other roles act to deter or to enhance the probability that people will take on caring responsibilities. In contrast, geographic proximity clearly is the most important descriptor of dyad characteristics. Previous findings show that caregivers are likely to live close to the care recipient.

Amount of time spent in caregiving tasks: A review of the current literature

Caregiving has been described as a labour-intensive responsibility (Abel 1990) in which work is done across a broad set of tasks. Despite this assertion, the exploration of determinants of amount of time spent in caregiving tasks is more limited than research on descriptors of caregiving, reviewed above. There has also been relatively little discussion of predictors of hours of care spent on particular eldercare tasks. In this section of the chapter, background studies on time spent caregiving are reviewed.

Characteristics of the caregiver: Gender is considered to be the most important predictor of hours spent on care to seniors. Women provide significantly more hours of eldercare than do men (Walker et al. 1995) on tasks such as personal care, social support and household work (Ingersoll-Dayton, Starrels and Dowler 1996; Tennstedt et al. 1993).

Age has also been found to predict hours of caregiving. In general, older adults spend substantially more time helping others than do younger adults (Gallagher 1994). Among specific caregiver tasks, older caregivers provide more help with transportation (Tennstedt et al. 1993). Neither education nor a rural versus urban residence has been found to be a predictor of time spent on caregiving.

Findings have been inconsistent concerning whether or not employment and other family obligations act as competing demands to hours spent in eldercare. Some have argued that marital status acts as a competing demand for married adult children who provide less help than their single counterparts (Stoller 1983). However, more recent work indicates that marital status of adult child caregivers does not predict hours of care (Eggebeen 1992). A contemporary argument is that competing family obligations such as marriage and the presence of young children do not reduce the time women devote to caring for an elderly parent. Rather, women caregivers tend to double up on their responsibility and cut back on leisure activities in order to fulfill all of their caregiving responsibilities (Dowler et al. 1992).

In contrast, there is more consistent evidence that employment status does influence hours of care. In a study of mother-daughter dyads in which mothers were widowed, Brody and Schoonover (1986) found that employed daughters provided significantly fewer hours of personal care and meal preparation. Primary caregivers who do not work in the paid labour force provide more hours of care per week than those who are employed (Penrod et al. 1995). The most important predictor of hours of care may be full-time (as opposed to part-time) employment status. Full-time employment may reduce by 20 hours a week the time allocated to informal help, while part-time employment has no statistically significant effect on hours of caregiving (Boaz and Muller 1992).

Characteristics of the care recipient: Among characteristics of the care recipient, gender and frailty have been found to be predictors of hours of eldercare. In general, women receive more hours of assistance than men (Ingersoll-Dayton et al. 1996; Spitze and Logan 1989). However, gender differences in receiving help may be explained in part by functional status, since women tend to have higher care needs. The recipient's degree of frailty has consistently been found to be associated with hours of care provided: hours of assistance increase with level of impairment of the recipient (Boaz and Muller 1992; Ingersoll-Dayton et al. 1996; Kemper 1992). In contrast, the age of the care recipient is not considered an important predictor of hours of assistance.

Characteristics of the caregiver-care recipient dyad: Proximity and relationship between giver and receiver are two characteristics of the caregiver-care recipient dyad that have been found to be predictors of the amount of time spent in caregiving. Spousal caregivers have been seen to provide the most hours of care, while friends provided the fewest hours of assistance. However, proximity may be a better predictor of hours of caregiving than the kinship relationship. Tennstedt et al. (1993) found that co-resident caregivers provided more hours of care than did non-co-resident caregivers. Their findings show that spousal caregivers are distinct in hours of care only from caregivers who do not live with the care recipient. The authors concluded that the caregiver's relationship to the elder recipient has little effect on hours of informal care after controlling for co-resident status.

The main effect of proximity on time spent caregiving appears to be in the distinction between living with the care recipient and living at a distance (Chappell 1991). For example, Hallman and Joseph (1995) examined data from a sample of 163 non-co-resident employed caregivers who were employees of eight Canadian industrial, service and public sector organizations. They found no significant differences in the incidence of the provision of each of the various types of assistance (activities of daily living and instrumental activities of daily living)¹ for women or men caregivers living at different distances from the care recipient.

There has been little research on the link between quality of the giver-recipient relationship and hours of assistance provided. However, research on mother-daughter dyads shows that daughters are more likely to perceive an obligation in the caring relationship than are mothers, and that those who feel a high obligation may also experience a reduction in feelings of intimacy (Walker et al. 1989). Caregivers may reduce their hours of caring if their relationship is strained or may continue to provide assistance with the risk of further deterioration in the quality of their relationship with the care recipient.

Longitudinal research on involvement in caregiving has shown a relationship between the length of time over which care is provided and the likelihood of remaining involved as a caregiver. In an analysis of data from two waves (two years apart) of the National Long-term Care Survey, Dwyer, Henretta, Coward and Barton (1992) found that 50% of children providing ADL and 30% providing IADL tasks during the first wave had stopped by the second wave. Although they do not report on hours of care, it seems likely that these may also be reduced with time.

¹ Activities of daily living (ADL) include bathing, dressing, going to the toilet, transferring, continence and feeding (Katz and Akpom 1976). Instrumental activities of daily living (IADL) include using the telephone, shopping, food preparation, housekeeping, laundry, transportation, taking responsibility for one's medications, and handling finances (Lawton and Brody 1969).

Most research on involvement in caregiving has been done with those who are identified as primary caregivers. By implication, these are the caregivers providing the most hours of assistance. Yet prior research does not present information about how many hours of care are provided by those who identify themselves as primary caregivers versus those who do not.

In summary, gender and age appear to be the strongest caregiver characteristics that predict time spent caregiving. Among competing demands, employment status and marital status are the main predictors. Both gender and degree of frailty of the care recipient are predictors, although the strongest may be frailty. Finally, among characteristics of the caregiver–care recipient dyad, proximity has been a consistent predictor of hours of care.

Results from the 1996 General Social Survey of Social and Community Support

Univariate results: A description of informal caregivers, recipients and tasks

The results presented here provide an overview of the people and tasks involved in eldercare in Canada and a comparison of women and men caregivers on variables thought to influence the amount of time spent in caregiving. This section presents the characteristics of caregivers, care recipients and the caregiver/care recipient dyad. In addition, the results presented here describe the types and total amount of time per week spent in caregiving tasks.

The sub-sample of the 1996 GSS used for analyses in this chapter comprises all respondents who indicated that they had, during the twelve months preceding the survey, done one or more of the specified set of care tasks for a senior (someone 65 and over) because of that senior's long-term health or physical limitations. There were 1,366 such individuals.

Who are the caregivers?

In 1996, nearly 11% of the population 15 years of age and over, or 2.1 million people, provided informal care to one or more seniors with a long-term health problem. It should be noted, however, that this average masks a great deal of variability. For example, women and men caregivers aged 45 to 59 are over-represented compared to the population while proportions of caregivers 60 and over are similar to the general population. Nearly 10% of middle-aged women provide care to seniors with long-term health or physical limitations. Further, we expect that the overall numbers of caregivers are an underestimation of the amount of caring done by Canadians. These statistics represent only those caring for a senior at the time of the survey. Yet many more people have taken or will take on eldercare responsibilities at some time during their lifetimes. Further, it must be reiterated that seniors with long-term health or physical limitations are among the most disabled and so most in need of care.

Women have been identified as the predominant caregivers and this survey confirmed that they do indeed constitute the majority of caregivers (61%). Indeed, higher proportions of women are caregivers than would be expected, given that women make up just 49% of the general population. Nevertheless, men represented a substantial group (39%) of caregivers. Because relatively little is known about men's characteristics as caregivers, or about the amount and type of care they provide, separate caregiver profiles for women and men are presented throughout this chapter.

Three sets of characteristics are used to describe caregiving. The first set focuses on the demographic variables—age, education and rural/urban residence—of the caregivers themselves. To highlight similarities and differences between caregivers and all Canadians, comparisons are made between women and men caregivers and women and men 15 and over in the population. A set of competing demands—marital status, labour force status, presence of children under age 15, and number of people cared for and length of time caregiving—is also part of the first set of characteristics examined in this section.

The second set of characteristics includes the demographic characteristics of care recipients, in particular, gender and age.

The third set of characteristics is concerned with the caregiver–care recipient dyad and includes the type and quality of the relationship between caregiver and care recipient, the proximity of the caregiver to the care recipient, and the status (primary or secondary) of the caregiver. Mean hours of caregiving per week are presented for women and men for the three sets of characteristics.

Characteristics of caregivers by average time spent caregiving

Age: The mean age of caregivers was 46 years for women and 44 years for men. This is slightly older than the mean age of the general population age 15 and over, in which the average age was 44 for women and 42 for men. The average age of caregivers in this study is younger than in other studies.

As shown in Table 3.1, there is great variation in the ages of caregivers. A similar proportion of women and men aged 30 to 44 and 45 to 59 were caregivers. A surprising proportion of men caregivers was very young—almost 20% were in their teens or twenties compared to 13% of women caregivers. The smallest proportion of caregivers was 75 and over.

Proportions of women and men in each age group differed somewhat from the general population. Women and men caregivers were over-represented among those aged 45 to 59 and under-represented among those aged 15 to 29.

The oldest caregivers, those aged 75 and over, spent the most time caregiving. The highest mean hours provided by women were reported by those who were 60 to 74 years old, while the highest mean hours provided by men were reported by those who were over age 75. This finding raises concerns about the vulnerability of older caregivers who may have health problems themselves.

Education: Somewhat higher proportions of men than women caregivers had a university education, while about one-third of women (36.7%) and of men (33.2%) had high school education or less. There were no strong patterns of educational differences between caregivers and non-caregivers.

Education has a different relationship to total hours of care for women and men. Among women, those with the least education provided the most hours of care; among men, those with high school education provided the most hours of care. It may be that women with higher education purchase some care services to reduce their hours of care. Men may keep their hours of care low enough that they can manage without purchasing outside assistance.

Table 3.1
Percentage of Group and Average Hours per Week Spent on Eldercare by Canadian Women and Men Caregivers, by
Caregiver Characteristics, 1996

Caregiver characteristics	Gender of caregivers				Group total	
	Women		Men		%	Mean number of hours/week
	%	Mean number of hours/week	%	Mean number of hours/week		
Age group						
15-29	12.5	4.6	18.6	2.8	14.9	3.7
30-44	33.1	4.2	33.9	2.8	33.4	3.7
45-59	36.6	4.8	31.0	2.6	34.4	4.0
60-74	14.8	7.5	12.6	4.0	13.9	6.2
75+	2.9	6.8	3.9	6.6	3.3	6.7
Highest level of education attained						
<High school	22.4	6.7	23.4	2.4	22.8	5.0
High school	14.3	5.5	9.8	5.4	12.6	5.5
Some postsecondary	19.2	5.1	15.7	2.7	17.8	4.2
Trade school/community college	30.3	3.6	26.6	3.2	28.9	3.5
BA+	13.8	4.8	24.6	2.5	18.0	3.6
Urban/rural residence						
Urban	72.7	4.7	79.1	3.1	75.2	4.0
Rural	27.3	6.0	20.9	2.9	24.8	5.0
Marital status						
Married/common-law	65.9	4.5	74.0	2.8	69.1	3.8
Separated/divorced	8.0	3.9	3.5	1.9	6.3	3.5
Widowed	7.9	7.7	1.5	12.0	5.4	8.2
Single	18.2	6.4	21.0	3.5	19.3	5.1
Labour force status						
Not in labour force	37.9	6.2	22.2	5.0	31.7	5.8
Employed part time	15.3	4.6	7.4	2.3	12.2	4.0
Employed full time	46.8	4.2	70.5	2.6	56.1	3.4
Presence of children under 15						
No children under 15	74.8	5.6	67.8	3.3	72.0	4.7
Children under 15	25.2	3.4	32.2	2.6	28.0	3.0
Number of people cared for						
1	27.8	6.2	33.1	3.3	29.9	5.0
2	30.7	5.4	33.4	1.9	31.8	4.0
3	21.2	2.9	15.2	4.5	18.8	3.4
4	11.5	6.2	12.8	3.5	12.0	5.1
5+	8.8	3.2	5.5	3.3	7.5	3.2
Length of time caregiving						
<6 months	13.5	7.1	12.9	2.4	13.3	5.3
6<12 months	10.2	4.6	11.5	2.8	10.7	3.8
1<2 years	16.1	4.2	15.1	5.5	15.7	4.7
2+ years	60.2	4.8	60.5	2.6	60.3	4.0

Source: Statistics Canada, General Social Survey, 1996.

Rural/urban residence: Overall, about 25% of caregivers lived in rural areas. The proportion of rural male caregivers was similar to that of rural males in the general population. In contrast, rural women caregivers were somewhat over-represented in comparison with the general population of rural women, while urban women caregivers were under-represented. This provides some evidence of a female informal rural support system.

While rural women gave slightly more hours of care than did urban women, there is little difference between the number of hours of care provided by urban and rural men. For men, these findings do not provide strong support for hypothesized higher amounts of care provided in rural areas.

Marital status: The marital status of women and men caregivers differed somewhat. Higher proportions of men than women were married, while higher proportions of women were separated and widowed. Compared with the general population, somewhat higher proportions of married men and married women were caregivers. Overall, marriage does not reduce the likelihood of being a caregiver.

Being married appeared to be a competing demand for both women and men. Those who were never married provided more hours of care than did those who were married. Although men provided fewer hours of care, patterns were the same for women and men. It could be argued that marriage is a competing demand for both women and men because being married entails more work. Alternatively, it could be argued that married men are able to provide fewer hours of care because they receive help from their wives with their caregiving tasks.

Labour force status: Higher proportions of men than women caregivers were in the labour force. Almost three-quarters of men (70.5%) and about half of women (46.8%) were employed full time. Women were twice as likely as men to be working part time and almost twice as likely not to be in the labour force. Women caregivers who were employed part time and men caregivers who were employed full time represented higher proportions than the general population. Contrary to expectations, employed caregivers were not under-represented compared with the general population.

Employment also acted as a competing demand for both women and men. Being employed was associated with providing fewer hours a week of caregiving. The main difference for women and men was between being employed and not being employed. The idea that part-time employment frees caregivers to be more involved in their caregiving activities was not borne out by these findings.

Presence of children under age 15: A minority of caregivers had children under age 15. Women caregivers with young children were under-represented in comparison with the general population. For women, it may be that having children to care for acts as a competing demand to caring for a senior. Alternatively, eldercare demands for those with young children may be low since such caregivers are likely to have relatively young parents.

Both women and men who had children under age 15 provided fewer hours of eldercare than did those with no children under 15. This finding suggests that time spent caring for children may compete with time spent caregiving.

Number of people cared for: Caregivers were likely to be providing care for more than one person. On average, women and men were caregivers for two people (2.48 for women and 2.27 for men). Women reported caring for as many as nine people, while men cared for up to seven. Over 40% of women and 30% of men cared for three or more people.

Caring for additional people was also expected to act as a demand competing with caring for the target elder. However, no clear patterns emerged. Women provided the highest number of hours of care to the target elder when they were caring for either one or four people. Men provided the highest number of hours when caring for three people. The explanation for these findings may lie in the types of tasks provided by those caring for several people. A caregiver may be able to provide higher hours of some tasks for the target senior if their other tasks, such as shopping, can be done for several people at once.

Length of time caregiving: Most caregivers had been providing assistance for a lengthy period. About 60% of both women and men had been caregivers for two years or more. This finding is not surprising given that caregiving was defined as assistance to someone with a health problem of a duration of six months or more. However, it does illustrate the long-term commitment of those providing eldercare. Women who had been caring for the senior for less than six months spent the most time per week providing care. In contrast, men's caring time was highest when they had been caring for one to two years. Differences may result from the types of tasks done for recipients. Higher proportions of women did housekeeping tasks, which may be needed most by recipients who are in the early phases of a chronic health problem and are still living in their own homes. In contrast, men may do more hours of care for those who have been ill for a longer time since men provide relatively more hours of personal care and transportation.

Characteristics of care recipients by average time spent caregiving

Gender: Nearly 70% of recipients of care were women. Although the majority of both women and men caregivers were providing assistance to women, slightly higher proportions of women (71.5%) than men (65.3%) caregivers provided care to women.

The gender of the recipient was associated with hours of assistance. Although there were greater numbers of women than men in receipt of assistance, women did not always receive more hours of care. Rather, both women and men caregivers provided more hours of care to persons of the opposite gender than to recipients of their own gender. (Table 3.2)

Table 3.2
Percentage of Group and Average Hours per Week Spent on Eldercare by Canadian Women and Men Caregivers, by Care Recipient Characteristics, 1996

Care recipient characteristics	Gender of caregivers				Total	
	Women		Men			
	%	Mean number of hours/week	%	Mean number of hours/week	%	Mean number of hours/week
Gender						
Women	71.5	4.3	65.3	3.4	69.1	3.9
Men	28.5	6.9	34.7	2.5	30.9	4.9
Age						
65-74	28.2	4.8	31.1	2.0	29.4	3.6
75-84	41.8	4.2	40.7	3.2	41.4	3.8
85+	17.7	4.4	19.1	2.0	18.3	3.4
Deceased	12.2	9.8	9.1	9.1	11.0	9.6

Source: Statistics Canada, General Social Survey, 1996.

Age/degree of frailty: The majority of women and men were providing care to seniors between 75 and 84 years old. However 19.1% of men and 17.7% of women provided care to seniors 85 and over. Approximately 10% had cared for someone who had died in the previous year. (The data did not include the care recipient's age at death.)

The only clear pattern of hours of care by age/degree of frailty of recipient was in the large number of hours of care provided by women and men to seniors who had died during the previous year. This is less a phenomenon of age than of frailty, since those who are near death generally require the most hours of assistance.

Characteristics of the caregiver-care recipient dyad by average time spent caregiving

Relationship between caregiver and care recipient: The data presented in Table 3.3 indicate that more than half of women and men caregivers (56.6% and 53.5%, respectively) were adult children providing care to their parents. However, less than 5% provided care to a husband or wife. In fact, after adult children, the largest proportions of caregivers were providing assistance to friends or to extended family members such as grandparents, aunts and uncles. Proportions in each relationship category were similar for women and men.

Table 3.3
Percentage of Group and Average Hours per Week Spent on Eldercare, by Caregiver-Care Recipient Dyad Characteristic, 1996

Caregiver-care recipient dyad characteristics	Gender of caregivers				Group total	
	Women		Men		%	Mean number of hours/week
	%	Mean number of hours/week	%	Mean number of hours/week		
Relationship of caregiver to care recipient						
Spouse/partner	4.9	15.8	4.2	16.3	4.6	16.0
Adult child	56.6	5.2	53.5	3.4	55.4	4.5
Sibling	3.7	5.4	3.4	2.5	3.6	4.4
Extended family	15.6	4.1	17.2	1.3	16.2	3.0
Friend	18.2	2.8	21.3	1.6	19.4	2.3
Other	1.0	1.5	0.4	0.6	0.8	1.3
Proximity						
Same household/building	15.8	13.7	10.7	9.3	13.8	12.3
Same neighbourhood/community	49.6	3.8	50.6	2.5	50.0	3.3
Surrounding area	21.8	3.4	22.8	1.9	22.2	2.8
<1/2 day away	9.3	2.1	11.9	3.3	10.3	2.6
>1/2 day away	3.6	4.0	4.0	0.5	3.8	2.5
Quality of relationship						
Very close	54.5	6.4	46.8	4.5	51.5	5.7
Close	30.5	4.2	30.1	1.9	30.4	3.3
Not close	15.0	1.8	23.1	1.6	18.2	1.7
Caregiver status						
Primary	39.0	8.8	27.0	6.2	34.3	8.0
Not primary	61.0	2.6	73.0	1.9	65.7	2.3

Source: Statistics Canada, General Social Survey, 1996.

Both wives and husbands provided far more hours of care than all other categories of caregivers. Since these are the most elderly caregivers, this finding underscores their high level of commitment to their spouse and raises questions about what their needs for support might be.

Proximity: The majority of caregivers lived near the senior care recipient. Half of all caregivers lived in the same neighbourhood or community, while another 20% lived in the surrounding area. Higher proportions of women (15.8%) than men (10.7%) lived with the care recipient.

Caregivers living with the care recipient provided more hours of care than did those living at a distance. Among those living with the care recipient, women provided substantially more hours of care than did men. Women caregivers living outside the household of the recipient did not differ greatly from each other in mean hours of care provided; however, men caregivers who lived the farthest away from the recipient provided the fewest hours of care.

Quality of relationship: While most caregivers described their relationship with the recipient as very close or close, a substantial minority, almost one-quarter of men (23.1%) and 15% of women, said their relationship was not close.

The quality of relationship between the giver and receiver of care was strongly associated with the average hours of care provided. Fewest hours were provided by those who saw their relationship as not close. Quality of relationship can be understood in two ways. "Not close" could represent a tension-filled relationship or one that is congenial but not intimate (such as might occur with a friend or neighbour). Fewer hours of care provided by those with relationships that are not close may be appropriate for neighbours who don't expect to have an intense caregiving role, as well as providing an important distancing mechanism in families with longstanding relationship problems.

Primary caregiver: Higher proportions of women (39%) than men (27%) reported that they were primary caregivers, indicating that women caregivers are more likely to have the main responsibility for the organization and provision of care.

Primary caregivers provided substantially more hours of care on average than did those who saw themselves as secondary caregivers. Self-defined caregiver status may be a good predictor of caregiving demands. It seems clear from this finding that primary caregivers not only have the most care responsibility, but also take on most of the caregiving work.

Life-cycle differences in caring: Table 3.4 provides an overview of life-cycle differences in relationships between caregivers and those for whom they are providing care. In this table, proportions within each age category of women and men who provided care for different groups of recipients are presented. This table provides an indication of how caregivers at different phases of the life cycle provided care to different groups of recipients.

Up to age 75, patterns are similar for women and men. The highest proportion of caregivers aged 15 to 29 were extended family members of care recipients, including grandchildren. In contrast, most of those aged 30 to 59 were adult children. Caregivers aged 60 to 74 were represented in all relationship categories, but the largest percentages of both women and men—32.5% and 44.8%, respectively—were caring for friends. Men caregivers over age 75 were most likely to be caring for spouses (47.6%), followed by friends (38.1%), while the highest proportion of women in this age group was caring for friends (52%).

Table 3.4
Relationship of Caregivers to Care Recipients, by Age Group and Gender of Caregiver, 1996

	% of caregivers in each age group									
	Women					Men				
	15-29	30-44	45-59	60-74	75+	15-29	30-44	45-59	60-74	75+
Relationship to care recipient										
Spouse	-	1.5	1.3	20.3	32.0	-	-	-	17.9	47.6
Adult child	15.4	71.3	73.0	29.3	-	22.0	69.2	79.0	10.4	-
Sibling	-	3.3	1.3	11.4	16.0	-	1.1	3.6	11.9	9.5
Extended family	73.1	9.1	6.9	5.7	-	56.0	11.0	3.6	13.4	4.8
Friend	6.7	14.9	16.4	32.5	52.0	21.0	18.1	13.8	44.8	38.1

Source: Statistics Canada, General Social Survey, 1996.

Table 3.5
Participation in Caregiving Tasks by Canadian Women and Men Caregivers, 1996

	% of caregivers participating in task		Mean number of hours/week	
	Women	Men	Women	Men
Caregiving task				
Meal preparation	40.2	19.0	5.0	4.0
Housekeeping	35.7	15.3	1.7	1.8
Maintenance/repair	18.5	42.8	1.5	1.0
Grocery shopping	48.8	40.9	0.9	0.8
Transportation	47.9	47.5	1.0	1.1
Bills and banking	27.1	24.2	0.3	0.2
Personal care	33.9	18.3	3.4	4.5
Checking up	57.3	50.0	*	*
Emotional support	32.9	22.9	*	*

* Data not collected.

Source: Statistics Canada, General Social Survey, 1996.

Type and amount of care provided

This section describes the different types and amounts of care provided. Care was measured across a set of nine tasks: meal preparation; housekeeping; home maintenance and repair; grocery shopping; transportation; bill paying and banking; personal care; checking up; and emotional support.

Table 3.5 shows proportions and average time of women and men caregivers involved in each of the nine caregiving tasks. Checking up was the care task most frequently reported by women (57.3%), followed by grocery shopping (48.8%), transportation (47.9%) and meal preparation (40.2%). Less than 20% of women provided home maintenance and repair. Men also reported checking up most frequently (50.0%), followed by transportation (47.5%), home maintenance and repair (42.8%) and grocery shopping (40.9%). Less than 20% of men provided meal preparation, housekeeping, or personal care.

Gender differences are evident in involvement in caregiving tasks. Higher proportions of women than men provided meal preparation, housekeeping, personal care, grocery shopping, banking and bill paying, checking up and emotional support. Higher proportions of men than women provided home maintenance and repair. Almost the same proportion of women and men provided transportation.

Most caregivers provided more than one type of task. On average, women performed 3.4 tasks while men performed 2.8.

Women not only performed a larger number of caregiving tasks, but they spent more hours doing these tasks than did men: women caregivers averaged 5.0 hours per week compared with men at 3.0 hours per week. On average, women and men spent the most hours doing meal preparation and personal care and the fewest hours paying bills and banking.

It is important to remember that the findings in this section are based on univariate analyses and do not take into account any interrelationships among independent variables. In the following section, we address these interrelationships by conducting multivariate analyses on predictors of involvement in care tasks. The following analysis, "Predictors of total time spent caregiving," provides a basis for comparison with the univariate results.

Multivariate results: Predictors of amount of time spent in caregiving tasks

This section presents results of multivariate analyses of predictors of the total time spent caregiving and of the amount of time spent in each of seven caregiving tasks. These results provide detailed information on the relative importance of the caregiver, care recipient and dyad characteristics in predicting the amount of time spent on caregiving tasks.

Respondents were asked a number of questions about their caregiving activities, including questions that permitted estimation of the amount of time they had spent providing care to a target senior during a twelve-month period. Stepwise regression analyses using these estimates of time spent performing individual care tasks and time spent performing all care tasks as dependent variables were conducted to identify the best predictors of the time spent caregiving. Potential predictors included a set of caregiver, care recipient and caregiver/receiver dyad characteristics believed to predict the amount of time family and friends devote to caregiving.² All analyses were run separately for women and for men as it was expected that different factors would influence the time men and women spent caregiving.

Variables that may predict hours of involvement in caregiving (Full model)

Caregiver characteristics

- ◆ Age (15–29, 30–44, 45–59, 60–74, 75+)
- ◆ Education (<high school, high school, some postsecondary, trade school/community college, BA+)
- ◆ Rural/urban residence
- ◆ Marital status (married/common law, separated/divorced, widowed, single)
- ◆ Labour force status (not employed, part time, full time)
- ◆ Presence of children under age 15
- ◆ Number of people (seniors and non-seniors) cared for having a long-term health or physical limitation
- ◆ Length of time caregiving (<6 months, 6<12 months, 1<2 years, 2+ years)

Characteristics of the care recipient

- ◆ Gender
- ◆ Age/frailty of the recipient (65–74, 75–84, 85+, died in the past year)

Dyad

- ◆ Relationship (spouse/partner, adult child, sibling, extended family, friend/neighbour)
- ◆ Proximity (same household, same neighbourhood, surrounding area, <1/2 day away, >1/2 day away)
- ◆ Quality of relationship (very close, close, not close)
- ◆ Primary versus secondary caregiver status

² Collinearity diagnostics revealed no significant multicollinearity problems, either in the form of pairwise correlations between, or linear combinations of three or more, predictor variables.

Each analysis had the same set of independent variables, including caregiver, care recipient and dyad characteristics. The dependent variables were total time caregiving and time spent in each of the following tasks: meal preparation, housekeeping, home maintenance and repair, shopping for groceries and other necessities, transportation, bill paying and banking, and personal care.

The reduced models, showing the statistically significant predictors of time spent in the various tasks by women and men care providers, are presented in Tables 3.6 to 3.21.

Predictors of total time caregiving

Women

Regression analysis showed that caregiver, care recipient and dyad characteristics that were important determinants of total time caregiving for women were, in order of significance: primary caregiver status; age/frailty of recipient; proximity; and quality of relationship (Table 3.6).

Primary caregivers: Whether or not a woman was a primary caregiver was the strongest predictor of total hours spent caregiving. On average, primary caregivers spent 3.6 hours per week more than did women who did not identify themselves as primary caregivers.

Age/frailty of recipient: Women caring for seniors who had died during the previous year spent 4.0 hours per week more on all care tasks than did women caring for someone aged 65 to 74. Caring for someone who had died during the previous year had particularly high caregiving demands, indicating the intensity of need of these recipients.

Proximity: Women who were not living with the cared-for senior but lived in the same neighbourhood, surrounding area, less than half a day or more than half a day away, provided between 7.7 and 9.8 fewer hours of care than women living with the care recipient, depending upon their location. The critical difference lay in the comparison between living with the recipient versus living at a distance.

Table 3.6
Predictors of Weekly Hours of Eldercare by Canadian Women
Caregivers, 1996
Reduced Regression Model

Independent variables	Mean number of hours spent on all tasks
Constant	11.2**
Primary caregiver	3.6**
Recipient – deceased	4.0**
Proximity – same neighborhood	-9.0**
Proximity – surrounding area	-8.8**
Proximity – <1/2 day away	-9.8**
Proximity – >1/2 day away	-7.7**
Quality of relationship – not close	-2.7**

F = 35.49
R square = .25

*** $p < .01$
* $p < .05$

Source: Statistics Canada, General Social Survey, 1996.

Quality of relationship: Women who described their relationship with the care recipient as "not close" performed 2.7 fewer hours of care than those who said their relationship was very close.

Men

Caregiver, care recipient and dyad characteristics that were important determinants of total time caregiving for men were whether the caregiver was a primary caregiver, age of recipient, length of time caregiving, number of people to whom caregiver provided care, relationship of caregiver to care recipient, and marital status of caregiver (Table 3.7).

Primary caregiver: Primary caregivers spent 2.5 hours per week more than those who did not identify themselves as primary caregivers.

Age/frailty of recipient: Men caring for someone who died in the previous year did 5.0 more hours of caregiving and men caring for someone 75 to 84 years old did 1.1

more hours of caregiving than men caring for someone 65 to 74. Similar to women, caring for someone who died during the previous year placed the biggest time demands on men caregivers.

Length of time caregiving: Men who had been caregivers for one to two years did 2.3 more hours per week of caregiving than men who had been caring for less than six months.

Number of people cared for: For each additional person cared for, men provided 0.6 more hours of caregiving per week. The competency demand of having others to care for resulted in increased rather than reduced hours of care to the target senior.

Relationship of caregiver to care recipient: Those caring for friends, extended family, parents, siblings and others performed between 10.9 and 13.0 fewer hours a week of caregiving compared with men caring for their spouses. Clearly spouses carry a relatively heavy caregiving workload.

Marital status: Widowers provided 4.1 more hours of caregiving per week than did those who were married. Widowers may have no one with whom to share their caregiving responsibilities. Nearly half of caregiving widowers were providing care to a friend. A significant minority of caregivers provided care to parents or to spouses who had subsequently died during the previous year.

Predictors of time spent on meal preparation

Women

Caregiver, care recipient and dyad characteristics that were significant determinants of time spent in meal preparation for women, in order of significance, included: primary caregiver status; gender of care recipient; marital status of caregiver; age of caregiver; relationship of caregiver to care recipient; proximity to care recipient; and age/frailty of recipient (Table 3.8).

Primary caregiver: Primary caregivers spent 2.3 hours per week more than women who did not identify themselves as primary caregivers.

Gender of the care recipient: Women caregivers spent 2.1 fewer hours on meal preparation for women compared with men recipients.

Marital status of caregiver: Widowed women did 1.8 more hours per week and single women 3.6 more hours per week than those who were married. Marriage acted as a competing demand, reducing the hours the care provider spent on meal preparation for the care recipient.

Age of caregiver: For every additional year in their age, women caregivers did 0.2 hours more meal preparation.

Table 3.7
Predictors of Weekly Hours of Eldercare by Canadian Men Caregivers, 1996

Reduced Regression Model

Predictor	Coefficient
Constant	12.2**
Primary caregiver	2.5**
Recipient – deceased	5.0**
Length of time caregiving – 1<2 years	2.3**
Number of people cared for	0.6*
Relationship – friend	-12.6**
Relationship – extended family	-13.0**
Relationship – parent	-11.1**
Relationship – sibling	-10.9**
Relationship – other	-12.8**
Age/frailty of recipient – 75–84 years of age	1.1*
Marital status – widower	4.1*
F = 25.42	
R square = .35	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Table 3.8
Predictors of Weekly Hours of Meal Preparation by Canadian Women Caregivers, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	2.5
Primary caregiver	2.3**
Gender of recipient – female	-2.1*
Marital status – widow	1.8
Marital status – single	3.6**
Age of caregiver	0.2**
Relationship – extended family	6.8**
Proximity – same neighborhood	-10.5**
Age/frailty of recipient – deceased	5.1**
Proximity – surrounding area	-10.1**
Proximity – <1/2 day away	-11.0**
Proximity – >1/2 day away	-10.2**
Relationship – parent	3.2**

F = 23.871
R square = .519

** p<.01
* p<.05

Source: Statistics Canada, General Social Survey, 1996.

Table 3.9
Predictors of Weekly Hours of Meal Preparation by Canadian Men Caregivers, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	-11.2**
Number of recipients	2.4**
Primary caregiver	5.9**
Age/frailty of recipient – 85+	-4.8**
Age of caregiver	0.2**
Presence of children <15	2.8*
Length of time caregiving 1<2 years	2.9*

F = 12.348
R square = .489

** p<.01
* p<.05

Source: Statistics Canada, General Social Survey, 1996.

Relationship of caregiver to care recipient: Women caring for a member of their extended family provided 6.8 hours more and women caring for a parent spent 3.2 hours more on meal preparation than women caring for a spouse. Caring for a spouse may be an example of the type of caregiving that goes unrecognized and unreported, especially in couples where the wife has always prepared the meals and the husband has always done the repairs and maintenance.

Proximity: Women living in the same neighbourhood, surrounding area, less than half a day away or more than half a day away did between 10.2 and 11.0 fewer hours of meal preparation than women living with the person they cared for. Clearly, those who live with the care recipient do much more meal preparation than do those who live at a distance.

Age/frailty of recipient: Those doing meal preparation for someone who died during the past year did 5.1 hours more than those caring for someone aged 65 to 74.

Men

Caregiver, care recipient and dyad characteristics that were important determinants of time spent in meal preparation for men, in order of significance, included: number of people to whom caregiver provided care; primary caregiver status; age/frailty of recipient; age of caregiver; presence of children under age 15; and number of years caregiving (Table 3.9).

Number of people cared for: For every additional person cared for, men spent 2.4 more hours per week preparing meals for the target recipient. For this task, the number of persons cared for did not act as a competing demand. Rather than reducing hours of care for the target recipient, men with multiple caregiving responsibilities had higher hours of meal preparation.

Primary caregiver: Primary caregivers did 5.9 hours more per week than those who did not identify themselves as primary caregivers.

Age/frailty of recipient: Men doing meal preparation for recipients 85 and over spent 4.8 fewer hours than those doing meal preparation for those age 65 to 74.

Age of caregiver: For every additional year of age, men spent 0.2 additional hours on meal preparation.

Presence of children under 15: Those who had children under 15 did 2.8 hours more meal preparation per week for the recipient.

Number of years of caregiving: Those providing care for one to two years, did 2.9 hours more per week than those providing care for less than six months.

Predictors of time spent on housekeeping

Women

Caregiver, care recipient and dyad characteristics that were important determinants of time spent on housekeeping for women, in order of significance, included: primary caregiver status; gender of care recipient; marital status of caregiver; age of caregiver; age/frailty of recipient; and relationship of caregiver to care recipient (Table 3.10).

Primary caregiver: Primary caregivers spent 0.5 more hours per week housekeeping than did women who did not identify themselves as primary caregivers.

Gender of care recipient: Caregivers spent 1.0 fewer hours per week housekeeping for female recipients compared with time spent housekeeping for male care recipients.

Marital status of caregiver: Single women provided 1.8 more hours of housekeeping than did married women.

Age of caregiver: For every year of age, women spent 0.4 more hours providing housekeeping.

Age/frailty of recipient: Women spent 1.4 more hours in housekeeping for recipients who had died in the previous year than for those aged 65 to 74.

Relationship of caregiver to care recipient: Women caring for a parent spent 0.8 more hours per week on housekeeping than women caring for a spouse.

Men

Caregiver, care recipient and dyad characteristics that were important determinants of time spent on housekeeping for men, in order of significance, included: proximity to care recipient; education of caregiver; primary caregiver status; and labour force status (Table 3.11).

Proximity: Men who lived less than one half day away from the care recipient spent 1.9 fewer hours housekeeping than men who lived with the recipient.

Table 3.10
Predictors of Weekly Hours of Housekeeping by Canadian Women Caregivers, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	-0.3
Primary caregiver	0.5
Gender of recipient – female	-1.0**
Marital status – single	1.8**
Age of respondent	0.4**
Age/frailty of recipient – deceased	1.4**
Relationship – parent	0.8**
F = 10.806	
R square = .211	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Table 3.11
Predictors of Weekly Hours of Housekeeping by Canadian Men Caregivers, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	2.0
Proximity – <1/2 day away	-1.9**
Education – high school	-1.9**
Primary caregiver	1.0*
Labour force status – part time	-1.9*
F = 5.742	
R square = .268	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Table 3.12
Predictors of Weekly Hours of Home Maintenance and Repair by Canadian Women Caregivers, 1996
 Reduced Regression Model

Predictor	Coefficient
Constant	-0.0
Primary caregiver	2.0**
Marital status – single	1.8**
Education – BA	1.5**
Education – high school	1.3*
F = 11.745	
R square = .260	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Education: Men with high school education spent 1.9 fewer hours housekeeping than those with less than high school education.

Primary caregiver status: Primary caregivers spent 1.0 more hours per week housekeeping than did men who did not identify themselves as primary caregivers.

Labour force status: Those employed part time spent 1.9 fewer hours housekeeping per week than those who were not employed.

Predictors of time spent on home maintenance and repair

Women

Caregiver, care recipient and dyad characteristics that were important determinants of time spent on home maintenance and repair for women, in order of significance, included: primary caregiver status; marital status; and education of caregiver (Table 3.12).

Primary caregiver status: Primary caregivers spent 2.0 hours per week more than women who did not identify themselves as primary caregivers on home maintenance and repair.

Marital status: Single women spent 1.8 hours per week more than married women on home maintenance and repair.

Education: Women who had completed a university degree spent 1.5 more hours and women with a high school education 1.3 more hours per week on home maintenance and repair than women with less than high school education.

Men

Caregiver, care recipient and dyad characteristics that were important determinants of time spent in home maintenance and repair for men, in order of significance, included: primary caregiver status; labour force status; and quality of relationship (Table 3.13).

Primary caregiver status: Primary caregivers spent 0.4 hours per week more on home maintenance and repair than men who did not identify themselves as primary caregivers.

Labour force status: Men who were employed full time spent 0.7 fewer hours per week on home maintenance and repair than those who were not employed.

Table 3.13
Predictors of Weekly Hours of Home Maintenance and Repair by Canadian Men Caregivers, 1996
 Reduced Regression Model

Predictor	Coefficient
Constant	1.9
Primary caregiver	0.4
Labour force status – full time	-0.7**
Quality of relationship – close	-0.8**
Quality of relationship – not close	-0.8**
F = 12.294	
R square = .188	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Quality of relationship: Compared with those who said their relationship with the care recipient was very close, those who reported their relationship was not as close spent 0.8 fewer hours on home maintenance and repair. Those reporting a close relationship also spent 0.8 fewer hours.

Predictors of time spent on shopping for groceries and other necessities

Women

Caregiver, care recipient and dyad characteristics that were important determinants of time spent on shopping for groceries and other necessities for women, in order of significance, included: primary caregiver status; quality of relationship; and number of years caregiving (Table 3.14).

Primary caregiver status: Primary caregivers spent 0.4 more hours per week shopping than women who did not identify themselves as primary caregivers.

Quality of relationship: Those who said their relationship was close spent 0.2 more hours while those who said their relationship was not close spent 0.4 fewer hours shopping than those caregivers who said their relationship with the recipient was very close.

Number of years caregiving: Women who had been providing care for more than two years spent 0.2 more hours on shopping than those who had been providing care for less than six months.

Men

Caregiver, care recipient and dyad characteristics that were important determinants of time spent on grocery shopping for men, in order of significance, included: presence of children under age 15; proximity of care recipient; labour force status; age of caregiver; primary caregiver status; age/frailty of recipient; number of years caregiving; marital status of caregiver; number of people to whom caregiver provided care; and quality of relationship (Table 3.15).

Presence of children under 15: Men with young children provided 0.3 fewer hours of shopping than those with no children under 15.

Proximity to the care recipient: Those who lived with the recipient did the most hours of shopping. Men who lived in the same neighbourhood as the recipient spent 0.4 hours per week less than did those who lived with the recipient.

Table 3.14
Predictors of Weekly Hours of Shopping by Canadian Women Caregivers, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	0.7
Primary caregiver	0.4**
Quality of relationship – not close	-0.4**
Length of time caregiving – 2+ yrs	0.2*
Quality of relationship – close	0.2*
F = 9.252	
R square = .093	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Table 3.15
Predictors of Weekly Hours of Shopping by Canadian Men Caregivers, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	-0.1
Presence of children <15	-0.3
Proximity – same neighborhood	-0.4**
Labour force status – part time	1.1**
Age of caregiver	-0.02**
Primary caregiver	0.2
Age/frailty of recipient – deceased	0.9**
Length of time caregiving 1<2 years	-0.4*
Marital status – single	0.5**
Age of recipient – 75–84	0.3**
Number of people cared for	-0.1**
Labour force status – full time	0.4*
Quality of relationship – close	-0.2*
F = 9.802	
R square = .386	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Labour force status: Employed men spent more time shopping. Those who were employed part time spent 1.1 more hours per week shopping—and those who were employed full time spent 0.4 more hours per week shopping—when compared with those who were not employed.

Age of caregiver: Older men spent more time shopping. For every year of age, men spent 0.02 fewer hours shopping.

Primary caregiver: Primary caregivers spent 0.2 more hours per week shopping than men who did not identify themselves as primary caregivers.

Age/frailty of recipient: Increased age/frailty of care recipient added to the time spent shopping by men. Compared with those caring for someone aged 65 to 74, men caring for someone who had died during the past year spent 0.9 more hours and those caring for someone 75 to 84 years old spent 0.3 more hours of shopping.

Number of years caregiving: In contrast to women caregivers, shopping time fell for men who had been caring longer. Men who had been caring for one to two years did 0.4 fewer hours of shopping than did those who had been caring less than six months.

Marital status: Single men caregivers provided 0.5 more hours of shopping than did married men.

Number of people cared for: For every additional person cared for, men spent 0.1 fewer hours of shopping for the target recipient.

Quality of relationship: Those who said their relationship was close did 0.2 fewer hours of shopping than those who said their relationship was very close.

Predictors of time spent on transportation

Women

Caregiver, care recipient and dyad characteristics that were important determinants of time spent on transportation for women, in order of importance, included: primary caregiver status; age/frailty of recipient; proximity of care recipient; labour force status; and gender of care recipient (Table 3.16).

Primary caregiver status: Primary caregivers spent 0.6 more hours per week providing transportation services than women who did not identify themselves as primary caregivers.

Age/frailty of recipient: Women caring for recipients who were 85 and over spent 0.5 fewer hours providing transportation than those caring for recipients aged 65 to 74 years old.

Proximity: Women who lived in the surrounding area provided 0.4 fewer hours of transportation than those who lived with the recipient.

Table 3.16
Predictors of Weekly Hours of Transportation by Canadian Women Caregivers, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	1.4
Primary caregiver	0.6**
Age/frailty of recipient – 85+	-0.5*
Proximity – surrounding area	-0.4*
Labour force status – full time	-0.3*
Gender of recipient – female	-0.4*
F = 7.522	
R square = .096	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Labour force status: Those who were employed full time spent 0.3 fewer hours on transportation than those who were not employed.

Gender of care recipient: Women provided 0.4 fewer hours of transportation to women than men recipients.

Men

Caregiver, care recipient and dyad characteristics that were important determinants of time spent on transportation for men, in order of significance, included: number of years caregiving; age/frailty of recipient; education of caregiver; and relationship of caregiver to care recipient (Table 3.17).

Number of years caregiving: Men who had been caring for six to 12 months provided 3.1 more hours of transportation than those who had been caring for less than six months.

Age/frailty of recipient: Men spent 1.5 more hours on transportation for recipients who had died during the past year than for recipients who were 65 to 74 years old.

Education: Men with university degrees provided 0.8 fewer hours of transportation per week than those with less than high school education.

Relationship: Men provided 0.7 fewer hours of transportation for extended family members than for spouses.

Predictors of time spent on bill paying and banking

Women

Caregiver, care recipient and dyad characteristics that were important determinants of time spent in bill paying and banking for women, in order of significance, included: urban/rural residence; presence of children under age 15; relationship of caregiver to care recipient; education of caregiver; and quality of relationship (Table 3.18).

Rural versus urban residence: Rural women spent 0.2 more hours on banking and bill paying than did those living in urban areas.

Presence of children under 15: Women with children under 15 spent 0.2 hours per week more on banking and bill paying than those without children under 15.

Table 3.17

Predictors of Weekly Hours of Transportation by Canadian Men Caregivers, 1996

Reduced Regression Model

Predictor	Coefficient
Constant	1.2
Length of time caregiving 6<12 months	3.1**
Age/frailty of recipient – deceased	1.5**
Education – BA+	-0.8**
Relationship – extended family	-0.7*
F = 12.334	
R square = .181	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Table 3.18

Predictors of Weekly Hours of Bills and Banking by Canadian Women Caregivers, 1996

Reduced Regression Model

Predictor	Coefficient
Constant	0.2*
Urban/rural – rural	0.2**
Presence of children <15	0.2**
Relationship – sibling	0.4*
Education – high school	0.3*
Quality of relationship – close	-0.1*
F = 5.963	
R square = .129	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Table 3.19
Predictors of Weekly Hours of Bills and Banking by Canadian Men Caregivers, 1996
 Reduced Regression Model

Predictor	Coefficient
Constant	0.3**
Quality of relationship – not close	0.2**
Age/frailty of recipient – 75–84	-0.1**
Presence of children <15	-0.1*
Proximity – <1/2 day away	-0.1*
Age of recipient – deceased	0.1*
F = 11.003	
R square = .329	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Relationship: Women caring for siblings spent 0.4 more hours per week banking and bill paying than those caring for spouses.

Education: Those with high school education spent 0.3 more hours per week banking and bill paying than those with less than high school.

Quality of relationship: Women who said their relationship was close spent 0.1 fewer hours per week on banking and bill paying than those who said their relationship was not close.

Men

Caregiver, care recipient and dyad characteristics that were significant determinants of time spent on bill paying and banking for men, in order of importance, included; quality of relationship; age/frailty of recipient; presence of children under age 15; and proximity of care recipient (Table 3.19).

Quality of relationship: In contrast to women, men who said their relationship was not close spent 0.2 fewer hours per week on banking and bill paying than those who said their relationship was close.

Age/frailty of recipient: Men caring for a senior aged 75 to 84 spent 0.1 fewer hours banking and bill paying than men who cared for someone aged 65 to 74. In contrast, men caring for someone who had died during the previous year did 0.1 hours more per week than did those caring for someone aged 65 to 74.

Presence of children under 15: Men with children under 15 spent 0.1 fewer hours on banking and bill paying than men without young children.

Proximity: Men who lived less than a half day away from the recipient spent 0.1 fewer hours banking and bill paying than men who lived with the recipient.

Predictors of time spent on personal care

Women

Caregiver, care recipient and dyad characteristics that were important determinants of time spent on personal care for women, in order of significance, included; primary caregiver status; age/frailty of recipient; proximity of care recipient; and relationship of caregiver to care recipient (Table 3.20).

Table 3.20
Predictors of Weekly Hours of Personal Care by Canadian Women Caregivers, 1996
 Reduced Regression Model

Predictor	Coefficient
Constant	5.8
Primary caregiver	2.0*
Age/frailty of recipient – deceased	4.4**
Proximity – same neighborhood	-2.1*
Relationship – sibling	-7.5**
Relationship – extended family	-5.0**
Relationship – parent	-3.3**
F = 9.330	
R square = .186	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

Primary caregiver status: Women who identified themselves as the primary caregiver spent 2.0 hours more per week on personal care than women who did not identify themselves as primary caregivers.

Age/frailty of recipient: Women caring for someone who had died during the previous year spent 4.4 hours more per week providing personal care than women caring for someone aged 65 to 74. This care was probably time-consuming palliative care.

Proximity: Those caring for someone in the same neighbourhood spent 2.1 fewer hours on personal care than those caring for someone who lived in the same household.

Relationship: Women caring for siblings provided 7.5 fewer hours, women caring for parents 3.3 fewer hours, and women caring for extended family 5.0 fewer hours of personal care than women caring for spouses.

Men

Caregiver, care recipient and dyad characteristics that were significant determinants of time spent on personal care for men, in order of importance, included: primary caregiver status; age/frailty of recipient; gender of care recipient; and number of people to whom caregiver provided care (Table 3.21).

Primary caregiver status: Men primary caregivers spent 4.6 more hours doing personal care than men who did not identify themselves as primary caregivers.

Age/frailty of recipient: Men provided 5.5 more hours of personal care for recipients who had subsequently died during the previous year than for those aged 65 to 74.

Gender of care recipient: On average, men provided 3.5 more hours of personal care for women than for men recipients.

Number of recipients: On average, with each additional person cared for, men spent 1.1 more hours in personal care for the target recipient.

Discussion

Two questions formed the basis for this chapter: Who are the informal caregivers to seniors with long-term health problems? What are the predictors of time spent caregiving? These questions are addressed in this section.

Descriptive data on caregivers presented in the first part of the analysis section of this chapter illustrate the diversity of Canada's caregivers and provide some data to challenge current wisdom about the characteristics of caregivers.

The fact that 11% of adult Canadians are involved in informal caregiving is an indication of a substantial informal labour force providing care to older Canadians with long-term health problems. Yet this group underrepresents the percentage of Canadians who, throughout their lives, will care for one or more seniors

Table 3.21
Predictors of Weekly Hours of Personal Care by Canadian Men Caregivers, 1996

Reduced Regression Model

Predictor	Coefficient
Constant	-2.9*
Primary caregiver	4.6**
Age/frailty of recipient – deceased	5.5**
Gender of recipient – female	3.5*
Number of people cared for	1.1*
F = 15.713	
R square = .434	
** p<.01	
* p<.05	

Source: Statistics Canada, General Social Survey, 1996.

with long-term health problems. The life-cycle patterns of who is caring for whom, though cross-sectional, are indications of the patterns that might occur throughout the lives of individual Canadians. The young care for extended family members; the middle-aged care for parents; and the oldest caregivers provide assistance to spouses and friends. Clearly, caregiving is an important contemporary issue for Canadians. It is likely that many Canadians will have a long, though perhaps not continuous, eldercare giving career.

The wide diversity in age of caregivers is an indication of how caregiving is integrated into the lives of Canadians. Many caregivers were younger than expected, given previous research. More caregivers are under 30 than 60 years and over. Some caregivers began their caring careers at a very young age. This does not mean that the roles of youngest and oldest caregivers can be equated. While many young caregivers may be supporting family members who are providing the primary care, seniors, except for the very oldest, are carrying greater caregiving responsibilities. Nonetheless, the common focus on middle-aged women caregivers appears to have made the work of others invisible.

Women predominated among caregivers. Yet men represented a larger segment of the caregiving population than was previously understood. Men also took on primary caregiving responsibilities, albeit in smaller proportions than did women. Like women, men caregivers had a variety of educational backgrounds. They were most likely to live in urban areas, be married, be employed, and have no young children at home. Similar to women, they were likely to care for more than one person, to care for those who are 75 and over, to live close to care recipients, and to have generally close relationships with the care recipients. Most women and men had been caregiving for two years or more.

The assumption that the main group of caregivers is adult children was supported. However, the relatively large groups of those caring for extended family members and for neighbours and friends was unexpected. This shows that caregiving responsibilities go beyond the nuclear family to nieces, nephews, grandchildren and other extended kin. One-fifth of caregivers were neighbours and friends, evidence that the caring society also reaches beyond family obligations. These caregiver profiles show that care to older Canadians is a role assumed by a broad segment of the population.

Data from the second question addressed in this chapter on the services caregivers provide additional information on the characteristics of caregivers. General findings from these analyses are that despite their similarities, women and men caregivers differed in ways that are important in understanding the nature of their caregiving activities. Women provided more total weekly hours of caregiving. Higher proportions of women than men did the gendered tasks related to homemaking, personal care and emotional support. Men predominated in instrumental activities such as home maintenance and repair. Tasks traditionally seen as the purview of men—driving and finances—are now done by similar proportions of women and men caregivers.

Table 3.22 provides a summary of characteristics of caregivers, care recipients and dyads that were significant predictors of hours spent in various caregiving tasks. It shows both similarities and differences in predictors of time spent by women and by men in caregiving tasks.

Among caregiver characteristics, age and education were the main predictors of hours of care in most caregiving tasks for both women and men. Age was a predictor variable for domestic activities (meal preparation for both women and men, housekeeping for women and shopping for men). Within these tasks, age operated differently for women and men. For each year of age, women did more hours of these tasks, while men did fewer.

Table 3.22

Predictors of Weekly Hours of Caregiving, by Characteristics of Caregiver, Care Recipient and Caregiver–Care Recipient Dyad, 1996

Predictor	Predicted tasks for caregivers	
	Women	Men
Characteristics of caregiver		
Age of caregiver	Meals, housekeeping	Meals, shopping
Education	Repairs, finances	Housekeeping, transportation
Urban/rural residence	Finances	—
Marital status	Meals, housekeeping, repairs	Total*, shopping
Labour force status	Transportation	Housekeeping, repairs, shopping
Presence of children <15	Finances	Meals, shopping, finances
Number of people cared for	—	Total, meals, shopping, personal care
Length of time caregiving	Shopping	Total, meals, shopping, transportation
Characteristics of recipient		
Gender	Meals, housekeeping, transportation	Personal care
Age/frailty	Total, meals, housekeeping, transportation, personal care	Total, meals, shopping, transportation, finances, personal care
Dyad characteristics		
Proximity	Total, meals, personal care, transportation	Housekeeping, shopping, finances
Relationship of caregiver to recipient	Meals, housekeeping, finances, personal care	Total, transportation
Primary caregiver	Total, meals, housekeeping, repairs, shopping, transportation, personal care	Total, meals, housekeeping, repairs, shopping, personal care
Relationship quality	Total, shopping, finances	Repairs, shopping, finances

* Total means all tasks.

Source: Statistics Canada, General Social Survey, 1996.

Urban/rural residence was a predictor of hours spent caregiving in only one care task. This may be a result of the way urban/rural was measured—there are no important distance or services differences between the two groups. Urban residence included all respondents living in urban core, urban fringe and urban areas outside Census Metropolitan Areas (CMAs). Rural residence included all respondents living in rural fringe areas and rural areas outside a CMA. Each group is likely to include people who are close to or at a distance from kin and from services.

Gender differences were more evident in variables representing competing demands. There has been a belief that other time demands such as having a spouse or young children to care for, as well as being in the labour market, will likely reduce the amount of time spent caregiving. Further, it has been argued that these competing demands will operate more strongly for men, providing a reason to reduce their hours of assistance. Findings from this study provide some support for these assumptions.

Overall, variables representing competing demands were more often predictors of time spent in caregiving for men than for women. As Table 3.22 shows, the demands of marital status, labour force status, presence of children under age 15, and number of people cared for were predictors of hours spent in a larger group of caregiving tasks for men than for women. These findings show that men more often reduce their hours of care in the face of competing demands than do women. For example, employed women caregivers provided fewer hours of care only for the task of transportation. Women who had children under

age 15 living with them provided fewer hours of assistance only in bill paying and banking. It seems that women find ways to accommodate the increased time demands of caregiving without reducing their caregiving hours.

Marital status was a competing demand for three tasks done by women and one task done by men. For these tasks, those who were not married did more than did those who were married. Labour force status also acted in the predicted direction. Where labour force status affected hours of caregiving, employed caregivers provided fewer hours of assistance. (The one exception was shopping, in which employed men performed more hours of caregiving than did those who were not employed.)

Care for dependent children has been seen as an important competing demand for time of caregivers. Those who have the demands of caring for both aging relatives and young children are often described as being part of the "sandwich generation." For women, having children under age 15 was a predictor of caregiving hours only for bill paying and banking. The presence of children added to hours spent caregiving, suggesting that rather than a competing demand, children were an additional demand and hours were cumulative. For men, presence of young children was associated with fewer hours spent shopping and banking and paying bills, but more hours spent in meal preparation. Clearly, we need to rethink the assumption that the presence of young children leads to reduced hours of caregiving.

The number of people to whom the caregiver provides care has also been hypothesized as a demand on the time of caregivers. Women and men cared for an average of two and as many as nine people. Yet for women, the number of people cared for did not predict hours spent in any caregiving task. Results were inconsistent for men. Although an increase in the number of care recipients was associated with decreased hours of shopping, it was associated with increased hours in meal preparation and personal care.

Among characteristics of care recipients, the age of the recipient was a predictor of hours of care in more tasks than was the gender of the recipient. In most cases, the significant age-related determinant of increased hours of care was whether the recipient had subsequently died during the previous year. Thus frailty rather than age appears to be a more reliable predictor of hours of care.

Among tasks where gender of care recipient was a significant predictor, women provided fewer hours of care and men performed more hours of care for women recipients. These differences may be explained by the tasks themselves. Women may do more for male recipients in household tasks such as housekeeping because men have fewer skills in these areas. In contrast, men were likely to provide personal care to their wives. High hours of care may be explained by the fact that personal care to a spouse may be considered too intimate to ask for assistance from others. Thus, the spousal caregivers may do this task alone.

Characteristics of the caregiver-care recipient dyad were predictors of hours of care for many of the caregiving tasks. Proximity was a predictor of hours of care for both women and men. In both cases, those who lived with the receiver provided more hours of care than did those who lived at a distance.

The caregiver's relationship to the care recipient was a predictor of hours of care in more care tasks for women than men. For ongoing household tasks such as meal preparation, women provided fewer hours of care to spouses than to parents or siblings. For personal care, they reported more hours to spouses than to parents or siblings. A possible explanation

for these differences is that household tasks done for an ill spouse may be underreported since they are a continuation of everyday activities in the household. In contrast, a woman may report household tasks done for a parent since they are likely to have commenced with the onset of the parent's health problem. In comparison, personal care is not usually done for a spouse as part of day-to-day activities in households. Higher amounts of personal care to spouses may reflect the fact that a wife may be doing most of this care herself, while care to other family members may be shared.

The caregiver's relationship was a predictor for only one task for men, who provide fewer hours of transportation to extended family members than to their spouses.

Being a primary caregiver was a frequent predictor of hours spent in a number of care tasks by both women and men. In all cases, primary caregivers provided more hours of care than did secondary caregivers, indicating that primary caregivers assume more responsibility and more of the work load than those who see themselves as secondary or supportive to the main caregiver.

The number of years a person had been caregiving was a predictor of hours of caregiving in only one task for women. Those who had been caring for more than two years provided more hours of shopping than those who had been caring for less than six months. This may be because, over time, needs for medical supplies add to hours spent in shopping for groceries and other necessities. Men's patterns were the same across all tasks. They provided more hours of care if they had been caring one to two years compared with those men who had been caring less than six months. Overall, these patterns show an increase in caregiving demands the longer a person has been in a caregiving role.

Relationship quality had an influence on hours of care in several types of tasks. Women and men who reported very close relationships provided more care than did those who reported relationships that were not close.

Overall, the main predictors of time spent doing eldercare tasks differed somewhat for women and men. The most frequent predictor for women was being a primary caregiver. Those who saw themselves as primary caregivers provided significantly more hours of care than did those who saw themselves as secondary caregivers. Second in importance for women's hours of care were three predictors: care recipient age or frailty, proximity and relationship to the care recipient. Women caring for seniors who lived nearby and who were caring for family members rather than for friends provided significantly more hours of care.

The most frequent predictors for men were the age or frailty of the care recipient and caregivers' status as primary caregivers. To a great extent, age was an indicator of frailty of the recipient. Most of the explained variance in hours of care was in care to very old recipients or to those who had died in the previous year. Like women, men who saw themselves as primary caregivers provided significantly more hours of care than did those who saw themselves as secondary caregivers. Thus, high hours of care were performed by men who were caring for old or frail recipients and who were primary caregivers. The third most frequent predictor was the number of people to whom the caregiver provided care. For some tasks, caring for an additional person increased hours of care to the target senior, while for other tasks, hours of care to the senior were reduced.

Patterns across caregiving tasks

Table 3.23 provides a different overview of predictors of time spent in caregiving tasks. In this case, sets of predictor variables for each caregiving task are presented. This table shows that patterns of predictors differ considerably across tasks and by gender.

Patterns by gender: For women, the most important predictor of hours of care across all tasks was being a primary caregiver. This was the first predictor of total time spent caregiving and hours spent in six of seven caregiving tasks (the exception being bill paying and banking).

Previous research has pointed to primary caregivers as those involved in the most intense caregiving tasks such as personal care, while those who were secondary caregivers are most highly involved in less intensive tasks such as shopping. However, findings from these analyses suggest that women who are primary caregivers do most tasks.

The same pattern was not found for men. For them, no one variable predominated across tasks as the most important predictor of time spent. Rather, sets of predictors were specific to particular tasks. This suggests that there may be more task specialization for men than for women caregivers.

Patterns across tasks: Among women caregivers there were similar patterns of predictors for some tasks. For example, each of the household tasks of meal preparation and housekeeping was likely to be done by women who were primary caregivers, who were unmarried and who were providing assistance to male care recipients. The profile of those providing personal care differed. Women doing this task were also primary caregivers. However, they were most likely to be providing personal care to someone who was frail (and had died during the previous year), who lived with them and who was their spouse.

Among men caregivers, household tasks such as housekeeping and home maintenance were more likely done by men who were primary caregivers and not in the labour force. Living with the care recipient increased caregivers' probability of doing housekeeping, while having a close relationship increased the likelihood of caregivers providing home maintenance. The quality of the caregiver–care recipient's relationship was a predictor variable in tasks that are optional (such as home maintenance and transportation), but not in tasks that must be done daily (such as meal preparation or personal care). It appears that when they have a choice, men may opt to provide assistance to seniors to whom they feel close.

Conclusion

Findings from this chapter illustrate the diversity of caregivers in gender, age and relationship. While women were more likely to be caregivers and to do more hours of care, men constituted a substantial proportion of caregivers. No one age group predominated, pointing out the likelihood of lifelong caregiving careers for many Canadians. Most were caring for relatives and most of those were adult children caring for parents. The breadth of caring obligations was seen in the numbers caring for extended family members and for neighbours and friends.

As is evident in the next chapter, caring is not without its costs. The impact on caregivers of their caring responsibilities provides an important backdrop to the debate over the costs and benefits of informal care.

Table 3.23
Predictors of Weekly Hours of Caregiving for Canadian Women and Men Caregivers, by Type of Task, 1996

Tasks	Caregiver characteristics	
	Women	Men
All tasks	Primary caregiver Age/frailty of recipient – deceased Proximity – lives with Relationship quality – not close < close	Primary caregiver Age/frailty of recipient – deceased Length of time caregiving – 1 < 2 years Number of people cared for Relationship – spouse Marital status – widowers
Meal preparation	Primary caregiver Gender of recipient – men Marital status – single Age of caregiver Relationship – extended family > spouse Proximity – lives with Age/frailty of recipient – deceased	Number of people cared for Primary caregiver Age/frailty of recipient – 85+ Age of caregiver Presence of children < 15 Length of time caregiving – 1 < 2 years
Housekeeping	Primary caregiver Gender of recipient – men Marital status – single Age of caregiver Age/frailty of recipient – deceased Relationship – adult child	Proximity – lives with Education – < HS Primary caregiver Labour force status – not employed
Home maintenance	Primary caregiver Marital status – single Education – BA, HS	Primary caregiver Labour force status – not employed Relationship quality – very close
Shopping	Primary caregiver Relationship quality – very close Length of time caregiving – 2+ years	Presence of children < 15 – none Proximity – lives with Labour force status – PT, FT > NE Age of caregiver – inverse Primary caregiver Age/frailty of recipient – deceased, 75+ Length of time caregiving – < 6 months Marital status – single Number of people cared for – inverse Relationship quality – very close
Transportation	Primary caregiver Age/frailty of recipient – 65–74 Proximity – lives with Labour force status – not employed Gender of recipient – men	Length of time caregiving – 6 < 12 months Age/frailty of recipient – deceased Education – < HS Relationship – spouse
Bill paying and banking	Urban/rural locale – rural Presence of children < 15 Relationship – siblings Education – > HS Relationship quality – close < not close	Relationship quality – close > not close Age/frailty of recipient – deceased, 75–84 Presence of children < 15 – none Proximity – lives with
Personal care	Primary caregiver Age/frailty of recipient – deceased Proximity – lives with Relationship – spouse	Primary caregiver Age/frailty of recipient – deceased Gender of recipient – female Number of people cared for

Source: Statistics Canada, General Social Survey, 1996.

CHAPTER 4

CONSEQUENCES OF CAREGIVING

How Does Caregiving Affect Caregivers?

"Any social interaction involves costs and benefits to the interactants. In the complex interactions of parent-caring, the costs and benefits are often subtle, indirect and difficult to calculate." (Archbold 1983, p. 42).

Caring for seniors is not without consequences. The literature suggests that caregivers experience both positive and negative outcomes when they take on caregiving responsibilities. Caregivers report such benefits as satisfaction, increased knowledge about themselves and about aging, a greater sense of mastery and self-confidence, closer relationships with those being cared for, and an increased tolerance for and understanding of others (Archbold 1983; Chapman, Ingersoll-Dayton and Neal 1994; Scharlach 1994; Scharlach, Lowe and Schneider 1991). However, research more often focuses on the "costs" of caregiving, revealing a wide range of negative outcomes. It is these negative consequences that are the focus of this chapter.

In an attempt to bring some order to the study of these negative consequences, several writers have tried to categorize them. "Caregiver burden," now widely used to describe the outcomes experienced by informal caregivers, encompasses physical, psychological, emotional, social and financial problems (Given, Collins and Given 1988). Burden is often viewed as having objective and subjective components. Objective burden comprises such practical impacts on caregivers as changes in daily routine, employment and health, while subjective burden refers to such emotional reactions to caregiving as low morale, anxiety and depression (Montgomery, Gonyea and Hooyman 1985). Parker (1990) classifies costs to informal caregivers as economic, physical and emotional.

The 1996 General Social Survey (GSS) included a number of questions designed to find out whether respondents had experienced a wide range of potential consequences as a result of their caregiving activities. Ultimately, these items were grouped empirically to determine the predictors of the consequences. This grouping was based on factor analysis results, which are reported in the methods section of this chapter. For the purposes of reviewing the literature, we group the consequences into the four general types that have been the focus of prior research: social; psychological or emotional; physical; and economic.

Social consequences

Prior research has indicated that caregiving responsibilities may interfere with caregivers' social and recreational activities, or affect the quality of their relationships with others. Caregivers frequently forego leisure, social activities, and personal development in order to fulfil their caregiving responsibilities (CARNET 1993; Hooyman, Gonyea and Montgomery 1985; Killeen 1990; White-Means and Chang 1994). For example, in a study by Archbold (1983), women caring for elderly parents reported that they were most affected by lack of freedom and by constraints on their personal, family and social time. Barusch (1988), Blieszner and Alley (1990), Brody (1985) and others also reported that eldercare providers had little time or energy left for social and recreational activities after attending to their caregiving responsibilities. Further, White-Means and Chang (1994) report that, when caregivers limit personal free time, their emotional and physical stress increase and life satisfaction decreases.

Some researchers have reported that improved relationships between caregivers and care recipients are a benefit of caregiving (Archbold 1983). Others have reported the opposite, that caregivers sometimes become irritated, even angry, at the person they are caring for (Archbold 1983; Boykin and Winland-Brown 1995; Given et al. 1988). Equivocal findings aside, caregiving has more consistently been found to have negative consequences for the caregiver's relationships with others, including spouse and siblings (Archbold 1983; Barusch 1988; Fitting *et al.* 1986).

Psychological consequences

Perhaps the most pervasive findings from prior research relate to the psychological impact of caregiving. Depression (Barusch 1988; Gallagher, Rose, Rivera, Lovett and Thompson 1989; Given et al. 1988; Parks and Pilisuk 1991), guilt (Barusch 1988; Brody 1985), worry/anxiety (Barusch 1988), loneliness (Barusch 1988) and, more generally, emotional stress, strain or burden (Baillie, Norbeck and Barnes 1988; Fast, Forbes and Keating 1999; Parker 1990; Parks and Pilisuk 1991) have all been attributed to caregiving. In fact, subjective burden is now an extensively researched and widely accepted outcome of caregiving (Given et al. 1988; Montgomery et al. 1985).

Physical consequences

Stress arising from time constraints may result in significant health problems. Employees with caregiving responsibilities have been found to experience more stress and more physical ailments such as headaches, loss of energy, gastro-intestinal disturbances and fatigue than employees without eldercare demands (Chapman et al. 1994; Hooyman and Gonyea 1990). It also has been reported that eldercaregivers experience sleep deprivation and/or changes in sleep patterns (CARNET 1993; Hooyman et al. 1985) which, if persistent, can negatively affect their health.

Economic consequences

Prior research identifies two types of economic consequences of caregiving: negative impacts on employment and associated earnings; and increased out-of-pocket expenditures.

Employment consequences: Caregiving has been found to have a variety of repercussions for the employment of caregivers. The positive consequences of eldercare demands generally contribute to better dynamics in the work environment. These include

increased self-confidence in handling difficult situations, and improved relations with co-workers through increased tolerance and understanding for others. However, far more attention has been paid to the negative consequences of caregiving demands on employment.

Lowered productivity, which was the most frequently mentioned effect of eldercare on employment in a study by Scharlach (1994), resulted from impaired concentration, fatigue, and caregiving-related emotional upset (Barling *et al.* 1994; Gibeau and Anastas 1989; Scharlach 1994). Stress and its resulting health problems can affect job performance.

Numerous authors have also reported a correlation between employee absenteeism¹ and eldercare responsibilities (Glendinning 1992; Gibeau and Anastas 1989; Gignac, Kelloway and Gottlieb 1996; MacBride-King 1990; Neal *et al.* 1993). Estimates of the amount of work missed because of eldercare demands range from a full week of work in the previous year (Gibeau and Anastas 1989) to 8.8 hours in the previous month (Scharlach 1994). Employees are often forced to utilize sick days, vacation and personal leave when they miss work in order to fulfil eldercare tasks (Finch and Mason 1990; Gibeau and Anastas 1989; Joseph and Hallman 1996; Kramer and Kipnis 1996).

Many employed caregivers change their work schedule by cutting back hours, limiting shift work and turning down overtime opportunities (Finch and Mason 1990; Glendinning 1992; Gibeau and Anastas 1989; Mutschler 1994). These caregivers balance their competing responsibilities by foregoing career opportunities such as meetings, training, extra projects and promotions (Glendinning 1992; MacBride-King 1990; Martin Matthews and Campbell 1995; Mutschler 1994).

Some caregivers have had to terminate employment because of eldercare demands (Franklin, Ames and King 1994; Martin Matthews and Campbell 1995). Martin Matthews and Campbell (1995) found that from 9% to 11% of employed caregivers relinquished employment because of caregiving responsibilities. Reasons for this vary. For example, Brody (1990) found that women quit paid work to look after their elderly relatives because they could not afford to purchase services, because they had inadequate help from other family members, or because they were caring for someone who refused to accept paid help.

Some studies have ranked work adjustment strategies: changing work schedules was found to be the first modification of choice, and terminating employment or changing employers was a last resort (Glendinning 1992; Mutschler 1994; Scharlach 1994). Eight of the 30 caregivers interviewed by Glendinning (1992) had modified their employment from full-time to part-time for a short period before terminating their employment completely. The most common reason for their decision to adjust their work or terminate employment was the physical decline of the care recipient, which required more hours of care and made it more difficult to manage employment and eldercare.

Out-of-pocket expenditures: Thus far, relatively little attention has been paid to other economic consequences of caregiving. A few authors have noted that caregivers often experience financial strain arising, in part, from out-of-pocket expenditures necessitated by their caregiving responsibilities (Archbold 1983; Given *et al.* 1988; Medjuck, O'Brien and Tozer 1992; Scharlach and Boyd 1989). Fast *et al.* (1997) describe the following sources

¹ Absenteeism includes long lunch breaks, work interruptions, or arriving late/leaving early in order to fulfill caregiving demands such as running errands or taking the elderly individual to medical appointments.

of additional expenditures: the purchase of goods and services for the senior care recipient; increased household spending when the senior resides with the caregiver; the purchase of services, such as child care and housekeeping, to “buy time” for the caregiver; and the purchase of services such as respite care, housekeeping, yard care and home adaptations for the care recipient.

Who Are the Caregivers at Greatest Risk?

The factors related to the consequences experienced by caregivers who take on caregiving responsibility are many and varied. In Chapter 3, three sets of factors—caregiver characteristics, care recipient characteristics and characteristics of the caregiver – care recipient dyad—were posited to be influential in determining how much time caregivers spend helping seniors. These same groups of factors are believed to be important predictors of the kinds and severity of consequences caregivers experience as a result of taking on eldercare responsibilities. In addition, the nature and magnitude of caregiving demands are likely to determine the impact of caregiving on an individual.

Caregiver characteristics

Gender: Evidence reported in Chapter 3, and in prior research, shows that women are more likely than men to provide eldercare and to spend more time at eldercare tasks. For this reason alone, they might be expected to be at greater risk than men of experiencing certain consequences. Moreover, it is likely that women and men will react differently to some of the other factors that are believed to influence the consequences that a caregiver experiences. For example, gender role socialization likely makes women feel more obligated to take on eldercare responsibilities (Aronson 1992; Walker *et al.* 1989). Women are also more likely to take responsibility for the more demanding and less flexible tasks of personal care, meal preparation, laundry and housecleaning (Martin Matthews and Campbell 1995), which may increase stress levels and interfere with social activities and employment. Indeed, a number of researchers have found that female caregivers report experiencing more psychological and/or emotional consequences (variously defined as “stress,” “anxiety,” “subjective burden” and “emotional strain”) than their male counterparts (Gallagher *et al.* 1989; Morris *et al.* 1991; Parks and Pilisuk 1991; Rankin 1990; Zarit, Todd and Zarit 1986).

Women are also much more likely than men to combine caregiving and employment responsibilities (Chapman *et al.* 1994; Gignac *et al.* 1996; Gottlieb, Kelloway and Fraboni 1994; Martin Matthews and Rosenthal 1996; Hooymann and Gonyea 1995). As a result, they also are more likely to experience employment consequences (Chapman *et al.* 1994; Duxbury *et al.* 1991; Gignac *et al.* 1996; Kramer and Kipnis 1995; MacBride-King 1990; Martin Matthews and Campbell 1995; Martin Matthews and Rosenthal 1996; Neal *et al.* 1990; Rosenthal, Martin Matthews and Matthews 1996). More specifically, female employees report more missed meetings, training sessions, business travel, or extra projects than their male counterparts (Gignac *et al.* 1996). Women also are more likely than men to adjust their work schedules, utilize sick days and vacation days, and miss work-related social events because of eldercare demands (Martin Matthews and Campbell 1995; Mutschler 1994; Neal *et al.* 1993). Women are twice as likely as men to report missed promotional opportunities (Martin Matthews and Campbell 1995). MacBride-King (1990) and Mutschler (1994) found that women are four times as likely as men to report having left a job because of eldercare demands.

In contrast, men reported more work interruptions than women (Gignac et al. 1996; Martin Matthews and Campbell 1995), where "interruption" is defined as being interrupted at work for at least 20 minutes within one month because of eldercare concerns. Perhaps this is a result of taking on eldercare management tasks, such as arranging for eldercare services and financial planning for the elderly family member, which require time on the telephone rather than time away from work.

Age: Evidence from prior research seems to suggest that younger caregivers may be more affected by caregiving responsibilities than older caregivers. Zarit, Reever and Bach-Peterson (1980) and Fitting *et al.* (1986) note that younger caregivers reported more strain than older caregivers. Gallagher et al. (1989) and Parks and Pilisuk (1991) also found that age was negatively related to depression, but only for male caregivers.

Similarly, Archbold (1983) found that younger caregivers were more engaged in career and social activities and so reported that caregiving impinged more on time with family and friends and work time. In contrast, Brody (1985) reported that it was older women who quit their jobs because of their caregiving responsibilities.

Education: In Chapter 3 it was suggested that caregivers with lower levels of education are less likely to consider employment as a career, have a lower stake in continuing employment, and thus are more willing to modify employment to meet caregiving demands (Boaz and Muller 1992; Stone and Short 1990). Some empirical evidence supports this. For example, Gottlieb et al. (1994) found that, when eldercare demands occurred, caregivers with higher education were at increased risk of experiencing stress and job costs such as missing meetings, and turning down business travel or extra projects. Higher educational attainment, which may be associated with higher-status, higher-paying jobs, may result in greater stress when conflicts with employment arise. In contrast, Gibeau and Anastas (1989) found that educational attainment is negatively correlated with absenteeism, suggesting that educational attainment may affect one's ability to manage eldercare and employment responsibilities simultaneously. However, Miller and McFall (1991) claim that recent studies fail to support any relationship between education and consequences for the employment of caregivers.

Employment status: Chapman et al. (1994) found that longer hours of employment were associated with greater stress on the part of employed caregivers. Spending more hours fulfilling the employment role may lead to a greater commitment to employment because of the greater amount of time invested and income received, compared with part-time employment. Glendinning (1992) found that full-time employees were less likely than part-time employees to give up their paid work. Dellasega (1990) reported that non-employed caregivers experienced more problems with their health.

Competing demands: Young children in the caregiver's household often compete with needy adults for the caregiver's time and attention. The same can be said of multiple eldercare demands. Generally speaking, competing demands are thought to increase the negative consequences of caregiving. Indeed, Brody (1985) found that daughter caregivers who faced competing demands were more likely than those without competing demands to give up their own free time and opportunities for social and recreational activities. White-Means and Chang (1994) similarly found that caregivers with young children had less leisure time than those without young children, while Given et al. (1988) found that adult children who are caring simultaneously for a parent and their own children were at greater risk of experiencing stress.

Multiple caregiving demands, defined as caring for an elderly individual and children or caring for more than one elderly person, have also been found to decrease job performance (Boyd, Miller and Hughes 1997; CARNET 1993; Gottlieb et al. 1994; MacBride-King 1990; Neal et al. 1993; Scharlach et al. 1991). More specifically, CARNET (1993) and Neal et al. (1993) concluded that employees with dual caregiving responsibilities reported the highest incidence of missing partial or full days of work. Other employment consequences linked to multiple caregiving demands are time stress, fatigue and mental preoccupation, which all affect job performance (Gottlieb et al. 1994; Joseph and Hallman 1996). Multiple caring demands were also correlated with missed business meetings and with the inability to take on extra projects, go on business trips, further education (Gottlieb et al. 1994; CARNET 1993) and work longer hours (Boyd et al. 1997).

The presence of a spouse could represent either a source of financial support and caregiving assistance (Boaz and Muller 1991) or an added demand (Cicirelli 1983; Stoller 1983). Baillie et al. (1988) suggested that marital status was not a significant predictor of stress or psychological distress, which could be explained by the fact that support from the partner and the demands of the marital role offset one another. Studies by Franklin et al. (1994) and Chapman et al. (1994) found that the support of a spouse was the best predictor of short-term adjustments to employment impacts (such as reducing the incidence of arriving late, leaving early and missing work) for the employed caregiver. However, MacBride-King (1990) and Walker, Martin and Jones (1992) found that married employed caregivers, when compared with unmarried employed caregivers, experienced greater time costs and difficulty in combining employment and eldercare demands. Spitze and Logan (1990) and Martin Matthews and Campbell (1995) found that the presence of a partner creates some demands and alleviates others. Chapman *et al.* (1994) concluded that the effects of having a spouse depend on the employment status of the partner. Other studies found the presence of a spouse had no effect on the management of eldercare demands and paid work (Neal et al. 1990).

Urban/rural residence: Seniors in rural areas are more likely than those in urban regions to be cared for by informal caregivers. Coward and Cutler (1989) and Dwyer, Lee and Coward (1990) suggest that this difference stems from a combination of rural values, kinship patterns and a comparative lack of services for chronically ill adults in rural areas. Because rural caregivers may face a greater obligation to care for elderly family members with fewer external sources of support available, it is possible that rural caregivers are more affected by their caregiving responsibilities than urban caregivers. Lee, Dwyer and Coward (1990) studied the living arrangements of seniors and found that urban residents were more likely to live with their adult children than were rural residents. While researchers have yet to address directly the relationship between geographic region and consequences of caregiving, a greater incidence of co-residence in urban areas may suggest that these caregivers will experience more social, psychological, physical and economic consequences.

Care recipient characteristics

Age/degree of frailty: In Chapter 3 it was noted that prior research has shown health status to be the most important predictor of whether seniors will require assistance. We also noted that physical and cognitive functioning tends to decline as people age (Lin and Rogerson 1995; Penrod et al. 1995; Tennstedt, Crawford and McKinlay 1993), so that as individuals get older they are more likely to receive some form of care (Himes, Jordan and Farkas 1996; Wilkins and Adams 1983). Generally speaking, this demand escalates as the care recipient gets older, and is likely to result in increasingly severe consequences for the caregiver. This expectation is reinforced by prior research. Baillie et al. (1988) and

Blieszner and Alley (1990) found that as the physical and cognitive impairment of the recipient increased, so did caregivers' stress, psychological distress and depression levels. Similarly, Brody (1985) found that women eldercare providers who quit their jobs had older, more dependent mothers. Employees caring for a cognitively impaired person were shown to have a higher incidence of leaving work early, extending breaks, utilizing uncompensated time or vacation days for eldercare tasks, and quitting their jobs than did employees caring for physically impaired elderly individuals (Scharlach 1989). Employees who cared for seniors with the highest levels of impairment rearranged their schedules, reduced their hours of work, and were at increased risk of leaving the work force (Gibeau and Anastas 1989; Gottlieb et al. 1994). Employees whose elderly kin suffered the highest level of impairment were the most likely to experience increased stress and work–family conflict (CARNET 1993; Gibeau and Anastas 1989; Gottlieb et al. 1991; Neal et al. 1993; Lechner 1993; Stoller and Pugliesi 1989; Walker et al. 1992).

Gender: It was noted in Chapter 3 that prior research demonstrates that senior women are more likely than senior men to receive informal care because they live longer and suffer from more long-term health conditions than men. Thus caregivers who assist older women probably face greater demands than those who help older men. In addition, there are some social taboos related to men performing certain tasks, such as personal care, for women (Hirsch 1996). The taboo seems not to apply to women caring for men. Thus, men who must provide this care to someone of the opposite gender (their mother or wife) may find it more stressful than do their female counterparts.

On the other hand, Westbrook and Viney (1983) suggest that senior women are likely to have bigger social and caregiving networks than men, with more people to share the care burden. Thus it is likely that someone caring for an elderly man may carry more of the load and be more burdened by the experience.

Characteristics of the caregiver–care recipient dyad

Relationship: It is generally argued that caregivers in closer kinship relationships feel more obliged to help recipients than those with looser ties, such as more distant family, neighbours and friends (Jacobson 1987; Qureshi 1990). However, the research results are somewhat mixed. Cantor (1983) found that the relationship between the caregiver and care recipient accounted for the greatest variance in the impact caregiving had on caregivers' lives. Barnes et al. (1992) and George and Gwyther (1986) found that spouses, because of their advanced age and greater sense of obligation to care for an ailing partner, were at greatest risk. Given et al. (1988), on the other hand, concluded that adult children are likely to have more competing role demands, so that caregiving responsibilities are more stressful and create more role conflict. However, neither Baillie et al. (1988) nor Zarit et al. (1980) found relationship to make a difference.

Evidence that gender and relationship are interrelated is found in the work of Zarit et al. (1986), who found that caregiving wives experienced more subjective burden than did caregiving husbands. Blieszner and Alley (1990) further found that wives and daughters do more of the demanding daily and weekly tasks while husbands and sons tend to do the intermittent, sporadic and, by implication, less burdensome tasks. The majority of eldercare providers were found to be daughters, followed by wives, then husbands, and finally, sons (Brody 1990). This would suggest that a greater proportion of women are caring for their elderly parents or parents-in-law, while men are more likely to be caring for their spouse.

Chapman *et al.* (1993) found that those who cared for a spouse and those who cared for a parent were equally likely to miss time at work.

Quality of relationship: Research has found that the quality of the relationship that exists between family members before caregiving relationships are established can have a profound impact on the amount of stress caregiving produces (Given et al. 1988). Poorer-quality relationships have been shown to be associated with higher levels of frustration, anxiety and perceived time stress for daughter caregivers (Walker et al. 1992; White-Means and Chang 1994) and with depression among people who care for Alzheimer's disease sufferers (Schulz and Williamson 1991).

On the other hand, McCarty (1996) found that daughters experience a more intense sense of loss and grief as a result of caring for parents with whom they have more positive relationships.

Proximity: It is generally believed that caregivers who reside with care recipients face greater care demands than those who care for seniors living in their own residences. Typically, care recipients who reside with their caregiver are more disabled and require more care. Indeed, caregivers who share the same house as the care recipient have been found to exhibit the highest levels of stress (Blieszner and Alley 1990; Cantor 1983), burden (Cochrane, Goering and Rogers 1997), interference with social activities and relationships (Walker et al. 1992), and interpersonal conflict because of shared space and loss of privacy (Brody 1990). Research by Joseph and Hallman (1996) showed that adult children who lived closer were called on more often; this situation precludes equitable sharing of eldercare demands among siblings. Similarly, Scharlach et al. (1991) found that two-thirds of their caregiver sample were the primary caregivers because they lived close to their parents' homes.

Several studies have concluded that living with an elderly family member is associated with difficulties in managing work and eldercare demands. For example, fatigue and mental preoccupation (Neal et al. 1993; Walker et al. 1992; Gottlieb et al. 1994; Ettner 1995) affect job performance. Ettner (1995) found that residing with a disabled parent was the most significant factor associated with reducing hours of paid work and leaving the work force. Conversely, Kossek *et al.* (1993) found that caregivers who did not live with their care recipient reported low rates of absenteeism.

Other studies found that residing with elderly kin improved the caregiver's management of full-time employment and eldercare demands because it eliminated some tasks, such as transportation and housework (Neal et al. 1993; Stueve and O'Donnell 1989). This may alleviate time pressure, allowing for easier management of paid work and eldercare tasks.

Primary caregiver: Most prior research on caregiving has focused exclusively on the primary caregiver and comparisons of primary and non-primary caregivers are not common. In the few instances in which such comparisons have been made, the evidence seems to suggest that primary caregivers are likely to experience more negative consequences than non-primary caregivers. Primary caregivers have been found to be more likely than other caregivers to experience physical exhaustion and disturbed sleep (Gottlieb, Kelloway and Fraboni 1994; Wallace and Noelker 1984), to be less likely to be employed (Penrod et al. 1995), to forego social and leisure activities, freedom and privacy (Archbold 1983; Gottlieb et al. 1994), to experience irritation, resentment, anger and frustration (Archbold 1983) and to exhibit higher levels of caregiver burden (Jutras and Veilleux 1991).

Length of time caregiving: Given et al. (1988) reported that, over time, as the nature of the care recipient's condition changes, as well as the demands associated with it, so do the amount and type of stress experienced by caregivers. Baillie et al. (1988) also found

that the number of years respondents had been caregiving was associated with the amount of stress, psychological distress and depression they experienced.

Although there is no research on the relationship between the length of the caregiving relationship and the impact of caregiving on employment, a study by Gottlieb and Gignac (1996) found that continuing or long-term caregiving demands contribute to stress in caregiving. This suggests that the longer the caregiving lasts, the more taxing it is on the caregivers' energy and time, and the more likely it is to result in increased conflict with paid work demands. The same study also concluded that respondents' coping mechanisms, in the face of eldercare demands, included positive reframing and the acceptance of the possible loss of highly valued activities such as employment.

Nature and magnitude of caregiving demands

Weekly hours of care: Numerous authors have noted that the amount of time spent performing eldercare tasks is associated with how caregivers are affected by caregiving demands. Care time has been found to be associated with the following: the degree of strain or burden experienced (Zarit, Reever and Bach-Peterson 1980); stress, psychological distress and depression (Baillie et al. 1988); and invasions on freedom and time for self, family and friends (Abraham and Berry 1992; Boykin and Winland-Brown 1995; Jutras and Veilleux 1991).

Several studies have concluded that the number of hours of care adversely affects employment. More hours of care are associated with more work interruptions such as telephone calls about eldercare issues (Chapman *et al.* 1993; Neal et al. 1993) and absenteeism (Franklin et al. 1994; Gottlieb et al. 1994). Some researchers have concluded that there is a threshold of hours of care that affects employment detrimentally. Ettner (1995), for example, found that individuals who provided care for more than 10 hours per week were more likely to leave the labour force.

Personal care: Montgomery et al. (1985) have argued that personal care tasks involve a level of intimacy and personal knowledge of the recipient that result in increased stress for the caregiver. Personal care tasks such as feeding and bathing, and closely supervising elders who wander or wake in the night, are cited by caregivers as being the most distressing (Rabins, Mace and Lucas 1982). Personal care tasks have also been correlated with greater time requirements, less flexibility and higher numbers of eldercare crises—all of which have greater impacts on employment than do instrumental care tasks (CARNET 1993; Gottlieb et al. 1994; Martin Matthews and Campbell 1995). These employment consequences include: absenteeism; interrupted work days; fewer shifts of work; missed business meetings and training sessions; and fewer business trips, promotions and extra projects. A study by Franklin et al. (1994) indicated that the best predictor for taking a leave of absence when eldercare demands arise was the number of hours of physical care.

Methods

With the exception of the employment consequences, the same subsample as in Chapter 3 was used for analyses intended to identify the most important predictors of the consequences of assuming eldercare responsibilities. Because the questions about whether caregiving responsibilities had affected the respondent's employment were asked only of

currently employed caregivers, the sample for these analyses was further limited to the 669 respondents who were eldercare providers and were employed.²

Respondents to the 1996 GSS were asked a number of questions about how their caregiving responsibilities had affected their lives. Responses to these questions were factor-analysed and the results were used to construct indices measuring five types of consequences.³ Results of the factor analysis, and reliability scores for each of the resulting indices, appear in Appendix I. The **socioeconomic** consequences index measures changes in social activities, holiday plans, sleep patterns and expenditures. The **guilt** index gauges respondents' feelings of inadequacy about the amount or quality of care they were providing. The **burden** index is a measure of the psychological and emotional hardships that arose from caregiving. The **job adjustment** index measures the extent to which employed respondents had made changes to their employment in order to meet caregiving demands. The **postponed opportunities** index reflects education/training or job opportunities that were delayed or foregone in order to provide care.

Stepwise regression analyses, using scores on the above indices as dependent variables, were conducted to identify the best predictors of the consequences of caregiving. Potential predictors included the same set of caregiver, care recipient and caregiver-care recipient dyad characteristics as was used to predict the amount of time spent providing care to seniors in Chapter 3. In addition, it was expected that the hours per week spent caregiving, and whether the individual had provided personal care, would also be important predictors of the consequences of taking on caregiving responsibilities.⁴ The model was run separately for women and for men, as different factors were expected to influence consequences experienced by women and men caregivers.

Results

Positive consequences of caregiving

As we mentioned in the introduction to this chapter, caregiving has been shown to have some positive outcomes for caregivers. The 1996 GSS offers only a brief look at the positive side of caregiving. Respondents were asked only three questions about the benefits of caregiving: whether their caregiving was a way of giving back what others had given them; whether caregiving was a way of giving back what life had given them; and whether helping someone strengthened their relationship with that person.

As Table 4.1 indicates, the vast majority of women and men respondents, indicated that their caregiving was

Table 4.1
Positive Consequences of Caregiving

	Women	Men	Total
	% responding affirmatively		
How often do you feel that ...			
a) by helping others, you simply give back what you have received from them?	81.2	77.2	79.7
b) by helping others, you simply give back what life has given you?	87.7	87.4	87.7
c) helping others strengthens your relationship(s) with them?	90.2	86.2	88.7

Source: Statistics Canada, General Social Survey, 1996.

² Limiting the sample to those presently employed presents a major limitation to the ability of our analysis to enhance our understanding of the implications of caregiving responsibilities for caregivers' employment as it omits what is perhaps the most critical employment impact: having to leave the labour force altogether.

³ Another set of questions which appear to measure the more positive consequences of taking on caregiving responsibilities also loaded together in the factor analysis. However, the reliability measure for the resulting index was too low to use the index as a dependent variable in our multivariate analyses. Descriptive statistics on these items are presented instead.

⁴ Collinearity diagnostics revealed no significant multicollinearity problems, either in the form of pairwise correlations between, or linear combinations of three or more, predictor variables.

Variables that may predict the consequences of caregiving (Full model)

Caregiver characteristics

- ◆ Age (15–29, 30–44, 45–59, 60–74, 75+)
- ◆ Education (less than high school, high school, some postsecondary, trade school/ community college, BA+)
- ◆ Rural/urban residence
- ◆ Marital status (married/common law, separated/divorced, widowed, single)
- ◆ Labour force status (not employed, part-time, full-time)
- ◆ Presence of children under 15
- ◆ Number of people cared for

Characteristics of care recipients

- ◆ Gender
- ◆ Age/frailty (65–74, 75–84, 85+, died in the past year)

Characteristics of the caregiver–care recipient dyad

- ◆ Relationship (spouse/partner, adult child, sibling, extended family, friend/neighbour)
- ◆ Proximity (same household, same neighbourhood, surrounding area, less than a half day away, more than a half day away)
- ◆ Quality of relationship (very close, close, not close)
- ◆ Length of time caregiving
- ◆ Primary versus secondary caregiver

Nature of the care provided

- ◆ Weekly hours of care
- ◆ Personal care provided

rewarding because it allowed them to reciprocate for their own good fortune and/or to enjoy a better relationship with those they were caring for. Perhaps these intrinsic rewards are what keep people involved despite the toll taken. On the other hand, these results also are consistent with the notion that it is a sense of generalized or specific obligation that helps motivate caregiving behaviour.

Socioeconomic consequences

The socioeconomic consequences of caregiving were measured in the survey by four questions relating to extra expenses and to changes in social activities, sleep patterns and holiday plans that arose from involvement in caregiving responsibilities.

As Table 4.2 shows, nearly half of all caregivers had to make changes to their social activities, and a similar proportion incurred extra expenses. More than one-quarter had their sleep patterns disturbed and nearly the same proportion had to change their holiday plans. For the most part, women and men were similarly affected. However, more women reported having their sleep patterns disrupted.

Table 4.2
Socioeconomic Consequences

	Women	Men	Total
	% of caregivers responding affirmatively		
Looking back over the past 12 months has helping others caused you ...			
a) to make changes in your social activities	46.7	44.7	45.9
b) to have extra expenses	41.8	45.3	43.2
c) to change your sleep patterns	31.1	25.0	28.7
d) to change your holiday plans	26.5	25.8	26.2

Source: Statistics Canada, *General Social Survey, 1996*.

Aggregating responses to questions about these four areas of impact—social activity, expenses, sleep patterns and holiday plans—produced an index that measured the number of socioeconomic consequences experienced by caregivers. Chart 4.1 shows that, on average, about three-quarters of caregivers reported little or no socioeconomic consequences from their work as caregivers, while nearly 25% of caregivers experienced serious socioeconomic consequences, as indicated by their affirmative replies to three or more of the questions on this topic.

Significant predictors of socioeconomic consequences

Regression analysis, using the socioeconomic consequence index as the dependent variable, allowed us to examine the underlying predictors of these consequences. The reduced models, showing the statistically significant predictors of the level of socioeconomic burden experienced by women and men caregivers, are presented in Tables 4.3 and 4.4.

Women

Caregiver, care recipient, and dyad characteristics that are important determinants of women caregivers' level of socioeconomic burden include the following, in order of significance: the number of hours of care per week; whether the respondent provides personal care to the recipient; the type of relationship; the age/degree of frailty of the recipient; the geographic proximity of the caregiver to the recipient; the level of education; the number of people the respondent cares for; and labour force status.

The number of hours per week women spent providing care was the strongest predictor of their scores on the socioeconomic consequence index. Chart 4.2 illustrates that the proportion of women caregivers reporting the highest level of socioeconomic impact increased markedly with the amount of time spent caregiving. Nearly half of women who had substantial caregiving demands of 7.5 hours per week or more responded positively to more than half the questions about socioeconomic consequences. Moreover, a significant minority (18%) of women was highly involved in caregiving, providing at least 7.5 hours per week of care. Not surprisingly, the more time they devote to caring for seniors, the less time caregivers have for social activities or sleep. This relationship holds even after controlling for other caregiver, care recipient and dyad characteristics. Regression results indicated that, for every additional

Chart 4.1

About 1/4 of caregivers experience high socioeconomic consequences

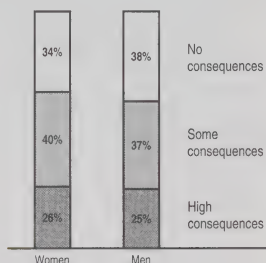
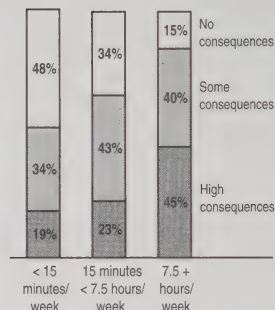


Chart 4.2

An average workday increases women's socioeconomic consequences



Source: Statistics Canada, General Social Survey, 1996.

Table 4.3
Socioeconomic Consequences of Caregiving for Canadian, Women, 1996

Reduced Caregivers Regression Model

Predictor	Coefficient
Constant	0.430**
Weekly hours of care	0.032**
Personal care	0.502**
Relationship – parent	0.488**
Age/frailty – deceased	0.764**
Proximity – <1/2 day away	0.611**
Education – high school	-0.393**
Number of people cared for	0.087**
Labour force status – full-time	0.216*

F = 25.272

R square = 0.211

** p<0.01

* p<0.05

Source: Statistics Canada, General Social Survey, 1996.

hour of care provided to the senior, women's index scores for socioeconomic consequences increased by 0.75% (0.03 on the four-point scale).

The provision of personal care to a senior also influenced the level of socioeconomic consequences experienced by female respondents. Thirty-nine percent of those providing personal care had high index scores for socioeconomic consequences (three or four on a four-point index), while only 20% of those who did not provide personal care experienced many socioeconomic consequences. According to regression results, women who provided personal care to an elderly friend or relative had higher scores (0.50 points, about 20%, higher) on the socioeconomic consequence index than their counterparts who did not provide personal care. Personal care tends to be highly demanding and unrelenting. Such demands are bound to interfere with the caregiver's scheduling of social and recreational activities and to disrupt sleep. Further, those receiving personal care also are more likely to require the caregiver to purchase special medical supplies and equipment.

The woman caregiver's relationship to the elder recipient was also an important predictor of the impact of caregiving on her social and economic well-being. Regression results showed that, on average, index scores for socioeconomic consequences are 0.49 points, or about 12%, higher for women caring for parents than for those caring for husbands. Since women tend to make holiday and social plans in conjunction with their husbands, if their husbands have long-term health or physical limitations, they are unlikely to have made such plans and so will not have to change them. Parental care probably carries a greater sense of obligation than caring for more distant relatives and friends, so women who care for parents are more likely to change plans in response to care needs than are those who care for other relatives or friends.

The age or frailty of the senior being cared for also increased the socioeconomic consequences of caregiving for women. As shown in Chart 4.3, the proportion of women who had been caring for a senior who died within the 12 months immediately prior to the survey, reporting high socioeconomic consequences was virtually double that of those caring for still-living seniors. Moreover, regression results showed that, even after controlling for other explanatory factors, women who had cared for a recently deceased senior had index scores for socioeconomic consequences almost 20% (0.76 on the four-point scale) higher than those caring for a still-living senior aged 65 to 74. It is likely that senior care recipients who died within 12 months of the survey were terminally ill and receiving palliative care from the respondent. It should not be surprising that caregivers would be more likely to have to curtail social activities, forego sleep and/or incur additional expenses as a result of caring for a dying senior.

Chart 4.3

Providing palliative care increases socioeconomic consequences for women

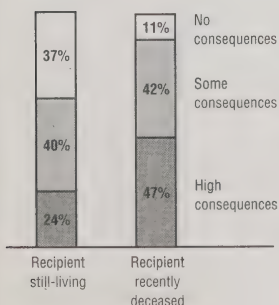
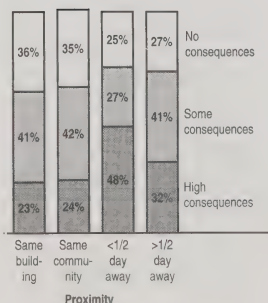


Chart 4.4

Women caregivers living at a moderate distance have the highest socioeconomic consequences



Geographic proximity also made a difference to women's social and economic well-being, as illustrated by Chart 4.4. Nearly half of those living several hours away (less than a half-day commute) from the care recipient reported high levels of socioeconomic consequences, compared with fewer than one-quarter of those who lived closer, or fewer

Source: Statistics Canada, General Social Survey, 1996.

than one-third of those who lived farther away. The regression results also showed that women who lived several hours away from the person they cared for had socioeconomic index scores more than 15% (0.61 points) higher than their counterparts who lived with the senior or in the same building. Caregivers who were several hours away likely lived close enough to be expected to help, but far enough away to make helping more difficult to manage. The commuting time involved for these women undoubtedly encroached on time available for social and recreational activities and sleep.

Regression results suggested that women who completed high school but did not pursue postsecondary education had the lowest index scores for socioeconomic consequences. These women reported index scores 10% (0.4 points) lower than women who had not finished high school. In contrast, socioeconomic consequences for women with higher levels of education were not significantly different from those of women with less than high school.

Helping more people was also a significant predictor of women's socioeconomic consequences. Regression results showed that women's scores on the socioeconomic consequences index increased by a little over 2% (0.09 points) with each addition to her caring roster. That is, after controlling for other predictive factors, caring for more people appears to leave less time and/or energy for social and recreational activities and sleep.

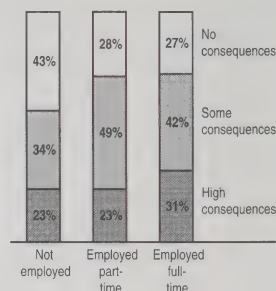
Paid work competes with caregiving responsibilities and personal activities for caregivers' time. Chart 4.5 shows that women employed full time had the highest socioeconomic index scores. Almost one-third of full-time employed women reported high index scores for socioeconomic consequences, compared with less than one-quarter of part-time employed women or non-employed women. Regression results, too, showed that the index scores for socioeconomic consequences of full-time employed women were higher by 5% (0.2 points on the four-point scale) than those of women who are not in the labour force. The double demands of full-time employment and eldercare appear to interfere with women's sleep and social activities. They also may choose to purchase help to meet their own or the senior's needs, thereby increasing their expenditures.

Men

As Table 4.4 shows, most of the same characteristics that predicted the level of socioeconomic burden experienced by women caregivers also predicted socioeconomic burden for men, though the order of importance is somewhat different. The reduced model for men, in order of significance, includes the following predictors: whether the respondent provides personal care to the recipient; the number of people the respondent cares for; the relationship between caregiver and recipient; the number of hours of care per week; geographic proximity; labour force status; the quality of the caregiver's relationship with the care recipient; whether the respondent is the recipient's primary caregiver; the caregiver's education; and the gender of the recipient.

Chart 4.5

Full-time employment increases women's socioeconomic consequences



Source: Statistics Canada, General Social Survey, 1996.

Table 4.4
Socioeconomic Consequences of Caregiving: for Canadian Men, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	-0.625**
Personal care	0.952**
Number of people cared for	0.262**
Relationship – parent	0.402**
Weekly hours of care	0.031**
Proximity – <1/2 day away	0.420*
Labour force status – part-time	-0.339
Quality of relationship – close	0.318**
Primary caregiver	0.350**
Education – some postsecondary	0.905**
Education – BA+	0.742**
Education – diploma/certificate	0.630**
Gender of recipient	0.225*

F = 19.223

R square = 0.343

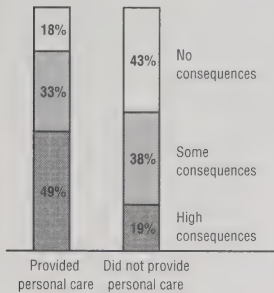
** p<0.01

* p<0.05

Source: Statistics Canada, General Social Survey, 1996.

Chart 4.6

Personal care escalates socioeconomic consequences for men



Source: Statistics Canada, General Social Survey, 1996.

The provision of personal care was the most important predictor of socioeconomic consequences for men. Chart 4.6 shows that a much higher proportion of men who provided personal care (49%) than of those who did not (19%) was severely affected by socioeconomic consequences. According to regression results, men who provided personal care to the senior scored almost a full point—0.95, or 25%—higher on the four-point socioeconomic consequence index than those who provided none. Personal care involves the provision of the most intimate day-to-day tasks—bathing, dressing, and grooming. The need for personal care is immediate and cannot be put off until a more convenient time. Thus those providing personal care to a senior are much more likely to have to cancel social and holiday plans, incur extra expenses, and/or change their sleep patterns.

The number of people cared for also increased men's socioeconomic strain. The more people men caregivers cared for, the higher their scores were on the socioeconomic consequences index. Only 20% of those caring for one or two people had high scores on the socioeconomic consequences index, while 35% of those caring for three or more had high scores (not shown). Regression results similarly indicated that, for every additional person cared for, men's scores on the four-point socioeconomic consequences index increased by about 6% (0.26). Clearly, the heavier the caregiver's caregiving load, the more social, recreational and economic sacrifices have to be made.

How men were related to the care recipient was the next most important predictor of socioeconomic consequences for men. Regression analysis showed that men caring for their parents had scores about 10% (0.40 points) higher on the four-point socioeconomic consequence index than men who were caring for their wives. It is likely that men who are caring for partners who are ill or disabled enough to require care will have few social engagements to forego since they would likely have been pursuing most social engagements with their wives.

Chart 4.7

More care time increases men's socioeconomic consequences

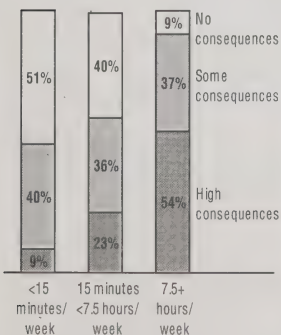


Chart 4.8

Men living at a moderate distance have the most socioeconomic consequences

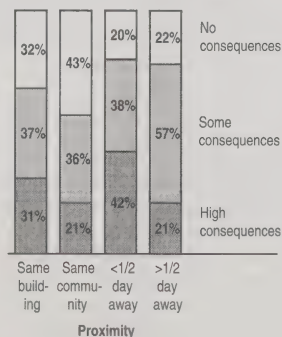


Chart 4.7 shows that the amount of time devoted to caregiving had a similar effect on men's index scores for socioeconomic consequences as on women's. The 11% of male caregivers who spent 7.5 hours or more per week reported the highest level of socioeconomic impact. More than twice as many of those men (54%) reported scores of three or more on the four-point socioeconomic index than those who did less than 7.5 hours of care (21%). Similarly, regression results showed that for every additional hour per week spent caregiving, men's socioeconomic index scores increased by 0.75% (0.03 points). As was found for women, the more time men devote to caregiving tasks, the less time is available for social or recreational activities or sleep.

Geographic proximity had a similar effect on men's and women's social and economic well-being. As Chart 4.8 illustrates, 42% of those living several hours (less than a half day) away from their care recipient reported high socioeconomic consequence index scores compared with 31% of those living in the same household or building as the senior, and 21% of those living more than a half-day commute away. Co-resident

Source: Statistics Canada, General Social Survey, 1996.

caregivers are highly likely to be caring for a spouse with long-term health or physical limitations and are then less likely to have social plans to cancel. However, even after controlling for other influences such as relationship and age/degree of frailty of care recipients, men living at a moderate distance still experienced more socioeconomic consequences than co-resident male caregivers. Regression results showed that men who lived less than a half day away from the person for whom they cared had socioeconomic index scores more than 10% (0.42 points) higher than those who lived in the same household or building as the senior. So it appears that the commuting time takes a significant toll on caregivers' social lives. Those living outside the same city but less than a half day away are probably close enough to be expected to provide caregiving but are faced with a commute that takes time away from recreational and social activities.

Results show that men who are employed part time report lower socioeconomic index scores than full-time employed men. However, so few male caregivers were employed part time that these results cannot be reported.

Regression results showed that men who reported their relationship with the senior to be close had index scores for socioeconomic consequences that were almost 10% (0.32 points) higher than those who felt very close to the senior.

Male primary caregivers reported higher index scores for socioeconomic consequences than their counterparts who were not primary caregivers. Regression results showed that primary caregivers' index scores for socioeconomic consequences were almost 10% (0.35 points) higher than those who did not identify themselves as the senior's primary caregiver. Primary caregivers are probably less able to turn over their caregiving responsibilities to someone else in order to go on vacation or to social events. The senior's extra financial needs also are more likely to fall on the shoulders of the primary caregiver.

Higher levels of education are also associated with higher levels of socioeconomic consequences for men. Regression results showed that those with some postsecondary education scored between 0.63 and 0.91 points higher on the four-point socioeconomic consequences index than those with less than high school education.

Finally, men caring for female seniors scored higher on the socioeconomic consequences index than men caring for male seniors. Men tend to assume caregiving responsibilities when there is no female relative available to do so. In such circumstances, the care required is likely to be quite demanding and so more likely to interfere with their social and holiday plans. Further, men are more likely than women to hire assistance, thus increasing their out-of-pocket caregiving expenditures.

Gender differences in socioeconomic consequences

Overall, similar proportions of women and men reported experiencing each of the socioeconomic consequences associated with assuming caregiving responsibilities that were examined in the survey. Women and men also exhibited similar scores on the socioeconomic consequences index and shared four of the five most important predictors of the level of socioeconomic consequences experienced: the hours they spent caregiving; whether they provided personal care; how they were related to the care recipient; and their geographic proximity to the recipient. However, these factors ranked somewhat differently in relative importance.⁵ Perhaps the most interesting contrasts can be seen in

⁵ The same conclusions are supported when the relative amount of variance explained by predictors for men and women is examined.

the relative importance of time spent caregiving and whether the respondent does personal care for the senior as predictors of socioeconomic consequences.

Weekly hours of care was an important predictor of socioeconomic consequences for both women and men. However, caregiving time was a more important predictor for women: care time entered first in the stepwise regression for women whereas it ranked fourth for men. Perhaps this is because more women (18%) than men (11%) spent the equivalent of a full workday (7.5 hours) each week caring for the senior. A comparison of Charts 4.2 and 4.7 also reveal that the proportion of highly involved respondents (those putting in 7.5 hours per week or more) who had the highest index scores for socioeconomic consequences was somewhat greater for men (54%) than for women (45%). However, since women have a longer workday than men when both paid and unpaid work are considered (Frederick 1995), we might expect that providing many hours of eldercare is likely to increase women's load to the point where they have to forego social activities and sleep in order to meet the increasingly pressing demands of both paid and unpaid work. Perhaps men are hiring more help for the senior and thus are likely to have more out-of-pocket expenses.

For men, the nature of the eldercare tasks being performed is a more important predictor of socioeconomic consequences than the time spent performing them. More specifically, being involved in the provision of personal care for the senior had the biggest impact on these consequences while care time ranked fourth. Being involved in personal care also ranked slightly higher as a predictor of socioeconomic consequences for men (first) than for women (second).⁶ In addition, a larger proportion of male than female personal care providers reported the highest levels of socioeconomic consequences (49% and 39%, respectively). Generally speaking, men are seldom socialized to expect to assume responsibility for providing for the personal needs of others, nor have they acquired the skills to do so. This is reflected in a much smaller proportion of male (18%) than female caregivers (34%) who provided personal care. Personal care tasks may be perceived by men to be more onerous and to interfere more with their personal lives.

Guilt

Guilt is another type of stress that caregivers are prone to experience. This study defines guilt as arising out of a sense of duty and responsibility to a person coupled with the perceived inability to meet their needs. Time and energy are limited resources in today's fast-paced world, and many caregivers just don't have enough time or energy to do all that should be done for their elderly friend or relative. Often, caregivers feel guilty because the competing pressures of a job and family do not allow them to do more. Many feel they

should be more efficient. And others may feel guilty because they do not have the essential skills to do a better job. Two questions in the survey explored caregivers' feelings of guilt.

As Table 4.5 shows, the majority of caregivers reported feelings of guilt about their caregiving responsibilities. About two-thirds of the men who were helping felt they should be doing more for the people they helped. The same proportion felt they could be doing a better job of helping. Nearly as many women felt they should be doing

Table 4.5
Feelings of Guilt

	Women	Men	Total
	% of caregivers responding affirmatively		
When giving help to another person or organization do you feel you ...			
a) should be doing more for the people you help?	60.9	66.7	63.2
b) could do a better job of helping?	52.5	66.9	58.2

Source: Statistics Canada, General Social Survey, 1996.

⁶ Personal care also explained a greater proportion of the variance in socioeconomic index scores for men than for women.

more; however, significantly fewer women (53%) than men (67%) felt they could be doing a better job. This may indicate that, relative to women, men lack some of the necessary skills and previous experience with many of the caregiving tasks and recognize their deficiencies. Alternately, they may lack confidence in their abilities to meet seniors' needs.

A guilt index, aggregating the above responses, was constructed to analyse the reasons for caregivers' feelings of guilt in greater depth. Men scored an average of 1.3 on the two-point scale, about 15% higher than the average reported by women (1.1). For illustrative purposes, these scores were categorized as follows: respondents who replied negatively to both questions experienced no guilt; respondents who responded affirmatively to one of the questions experienced moderate feelings of guilt; and those who answered yes to both questions were considered to feel high levels of guilt.

As Chart 4.9 illustrates, many Canadians appear to be concerned about their ability to carry out their caregiving tasks, with nearly half reporting a high level of guilt. Women were less likely to suffer from high levels of guilt than were men (44% and 57%, respectively).

Significant predictors of guilt

As with other consequence indices, regression analyses were used to identify the significant predictors of the level of guilt experienced by eldercare providers. Guilt index scores were the dependent variable in these analyses. The reduced models, showing the statistically significant predictors of the level of guilt experienced by female and male eldercare providers, are presented in tables 4.6 and 4.7. As with other indices, results differed for men and women and so are discussed separately below.

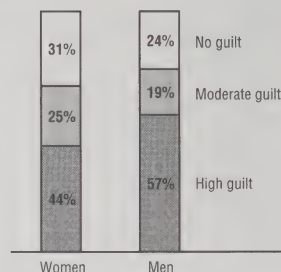
Women

Among the caregiver, care recipient, and caregiver—care recipient dyad characteristics included in the model, the most significant determinants of guilt index scores for female caregivers, in order of significance, were as follows: the woman's age; whether she was the recipient's primary caregiver; the presence of children under 15 years of age; the quality of her relationship with the senior; her education; her marital status; her urban or rural residency; and geographic proximity to care recipient.

Age was the most important predictor of the level of guilt reported by women caregivers. Chart 4.10 clearly illustrates that younger women were much more likely than older women to feel high levels of guilt about their caregiving activities. About three out of five young women under 30 felt a high level of guilt, compared with two out of five mid-aged women (30 to 69 years of age) and one out of five older women (aged 70 and over). Similarly, regression analysis revealed a negative relationship (-0.02) between age and guilt: with each additional year, guilt declined slightly. This age-related decrease in the level of guilt could be attributed to several factors. Because older women have more experience and greater competence, they may be less likely to doubt

Chart 4.9

Men carry more guilt about eldercare than women



Source: Statistics Canada, General Social Survey, 1996.

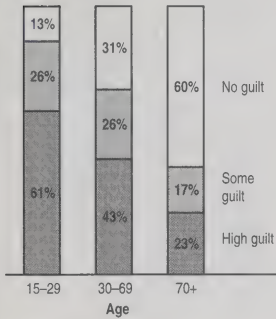
Table 4.6
Guilt Consequences of Caregiving for Canadian Women, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	1.911 **
Age of respondent	-0.017 **
Primary caregiver	-0.237 **
Presence of children <15	-0.388 **
Quality of relationship – close	0.200 **
Education – BA+	0.329 **
Marital status – single	-0.215 *
Education – diploma/certificate	0.189 **
Rural/urban residence – urban	0.168 *
Proximity – <1/2 day away	0.357 *
F = 13.643	
R square = 0.141	
** p<0.01	
* p<0.05	

Source: Statistics Canada, General Social Survey, 1996.

Chart 4.10

Younger women feel more guilty about eldercare



Source: Statistics Canada, General Social Survey, 1996.

how effectively they are carrying out their caregiving tasks. As women get older, they also assume myriad roles—wife, mother, eldercaregiver and paid worker. The fact that they are meeting greater day-to-day responsibilities may be why they feel less guilty than younger women with fewer other demands on their time. Similarly, senior women, with diminishing health and energy levels, may feel less guilty because they are doing all they can.

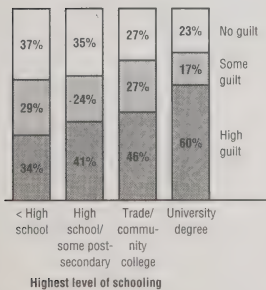
Being a primary caregiver was also an important predictor of guilt. Women who identified themselves as primary caregivers had lower levels of guilt than other caregivers. The proportion of women who felt most guilty jumped from one-third among primary caregivers to slightly more than half for women who were not the primary providers of care. This result is also reflected in regression results. Women who were primary caregivers scored 12% (0.24 points) lower on the guilt index than those who were not primary caregivers. It appears that women who are not able to assume the role of primary caregiver are more likely to feel guilty.

The presence of children was also strongly associated with women's guilt levels. Regression results indicated that mothers scored 19% (0.39) lower on the guilt index than other women. That is, having to meet child care demands in addition to eldercare demands was associated with less pronounced feelings of guilt. Women may feel a greater obligation toward their children than toward their senior relatives and friends, and the need to meet this competing demand lets them "off the hook" to some extent with respect to eldercare responsibilities.

The quality of a female caregiver's relationship with the person for whom she was caring also played a determining role in feelings of guilt. Regression results revealed that women who felt close to the senior had scores 10% (0.20 points) higher on the guilt index than their counterparts who felt very close. Perhaps respondents who reported that they felt close experienced more ambivalent feelings about their caregiving activities than those who were unquestionably at either end of the emotional spectrum, and this ambivalence subjected them to a heavier guilt load. Probably those who were very close were trying the hardest and had the least to feel guilty about; those not close to the senior weren't bothered by fears that they were not doing more or better. It was those who felt ambivalent who were bothered.

Chart 4.11

Education increases women's guilt about their eldercare activities



Source: Statistics Canada, General Social Survey, 1996.

Chart 4.11 illustrates a positive relationship between education and feelings of guilt. Women who had at least a bachelor's degree were almost twice as likely (60%) to report the highest guilt scores as were those without a high school diploma (34%). This finding was confirmed by regression results showing that women with either a bachelor's degree or a trade school or community college certificate scored about 17% (0.33 points) and 9% (0.19 points), respectively, higher on the guilt scale than women with lower levels of education. Perhaps more highly educated women, who also are more likely to be pursuing careers, feel conflicted about the role they have chosen for themselves. Clearly, society expects wives and daughters, much more than husbands and sons, to provide care for ailing spouses and parents. As a result, professional women are more likely to feel guilty about the amount or kind of support they can offer. They also probably face heavier employment demands and so are able to do less or do less well and, as a result, have more to feel guilty about.

Regression analysis, which held other explanatory factors constant, suggested that single women suffered less guilt than married women did. Single women scored 11% lower (-0.22 points on the two-point guilt index) than married women. In the absence of other family responsibilities, single women are probably able to devote sufficient energy and attention to eldercare so they are less likely to feel like they should be doing more or better for the senior.

Higher proportions of rural inhabitants experience higher levels of guilt than their urban neighbours. Regression analysis showed rural residents' guilt scores to be nearly 9% higher (0.17 on the two-point index) than urban dwellers'. It is likely that rural people have a greater sense of community and are more aware of the caregiving needs of friends and neighbours than residents of the more faceless societies found in cities. A greater awareness of unmet needs can lead to greater feelings of guilt.

Chart 4.12 illustrates that guilt increases for women the further away they live. The proportion reporting high levels of guilt almost doubles, from about 40% for those living less than half a day away to 77% of caregivers living at a greater distance. Greater distance probably prohibits women's direct involvement in care, prompting feelings of guilt.

Men

As Table 4.7 shows, three of the characteristics that predicted feelings of guilt among female caregivers were also predictors of guilt for men: age of the respondent; the presence of children under 15 years of age; and education. The reduced model for male caregivers, in order of importance, included labour force status, the age of the caregiver, the number of people the respondent cares for, the length of time providing care, the presence of children under 15, the education of the caregiver, the gender of the care recipient, and the number of hours spent in caregiving per week.

Labour force status was the most important predictor of guilt levels for men. As Chart 4.13 depicts, almost twice as many full-time employed men (65%) as non-employed men (34%) had high levels of guilt. This observation was also reflected in the regression results. Men who were employed full time scored almost 15% (0.29 points) higher on the guilt index. Part-time employment is a common coping strategy for juggling work and family responsibilities. It is a strategy adopted mainly by women, but these results suggest that it works equally well for men with caregiving responsibilities. Further, the proportion of part-timers who felt most guilty (45%) was more similar to the non-employed than to the full-time employed. Male caregivers who are employed full time are seen as having a legitimate excuse for not doing as much or not doing a better job.

Age was an important predictor of guilt feelings for men, as it was for women. Chart 4.14 illustrates that, as male

Chart 4.12

Women living at a distance feel most guilty about their eldercare activities

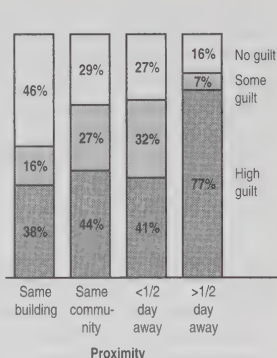
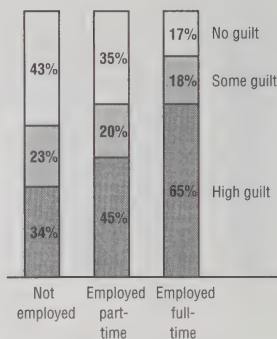


Chart 4.13

Full-time employment increases men's guilt about their eldercare activities



Source: Statistics Canada, General Social Survey, 1996.

Table 4.7
Guilt Consequences of Caregiving for Canadian Men, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	1.079**
Labour force status – full-time	0.293**
Age of respondent	-0.009**
Number of people cared for	0.114**
Length of time caregiving – 6<12 months	-0.286**
Presence of children <15	0.258**
Education – some postsecondary	0.286**
Gender of recipient – female	0.201**
Weekly hours of care	0.016*

F = 14.783

R square = 0.198

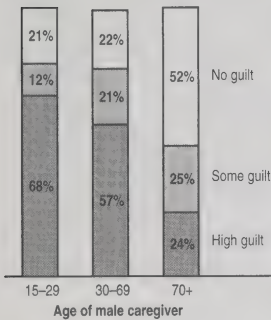
** p<0.01

* p<0.05

Source: Statistics Canada, General Social Survey, 1996.

Chart 4.14

Younger men feel more guilty about their ability to care for a senior



Source: Statistics Canada, General Social Survey, 1996.

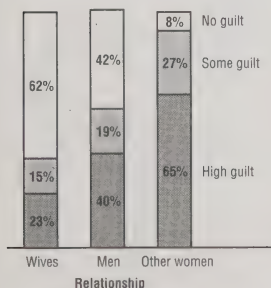
caregivers aged, the proportion who felt very guilty about their caregiving activities declined markedly. The proportion of very guilt-ridden older caregivers (24%) was much less than half that of their younger counterparts (68%). Regression results also showed that, on average, the guilt index score decreased slightly (by 0.01 points) with each additional year. This may be caused in part by a cohort effect. Older men may not be as guilt-ridden as younger men simply because they do not consider caregiving to be their responsibility, never having been socialized to do so. In the past, gender roles were more clearly delineated: men were responsible for the financial support of the family, women the caregiving. More women are now sharing the family's financial burden. And, while women maintain primary responsibility for the household and family, younger men may have developed a greater sense of responsibility. This may be why they feel guilty about not doing more of the caring work. Experience, and the feeling of competence that comes with it, may also help explain these age differences.

The number of people to whom men caregivers provided assistance was positively related to levels of guilt. Men who were helping three or more people were most likely to feel very guilty (68%). Similarly, regression analysis showed that guilt index scores increased by 6% (0.11 points) with each additional care recipient. It is likely that each addition to the caring roster increased the total amount of work involved, leaving less time and energy to devote to each individual senior. The increased caregiving responsibility increased the likelihood that male caregivers felt they should somehow be doing more, or better at, caring for their relatives or friends.

Regression results indicated that men who had been providing care for between six and 12 months scored almost 15% (0.29 points) lower on the guilt index than those who had been caring for the senior for less than six months. This finding may suggest that men acquire the necessary caregiving skills with somewhat longer experience, learning how to cook, clean, bathe and provide other care more efficiently and effectively. This new competence could lead to fewer guilty feelings about their caregiving activities.

Chart 4.15

Personal care for non-spousal women increases guilt levels for men caregivers



Source: Statistics Canada, General Social Survey, 1996.

In contrast to mothers, men with children experienced higher levels of guilt than did childless men. The proportion of men who felt very guilty rose from about half of childless men to more than two-thirds of fathers. Regression results also indicated that the guilt index scores of men caregivers with children under age 15 were about 13% higher (0.26 points) than other men's. This phenomenon may be a product of our socialization experiences. Perhaps, unlike the more balanced upbringing of children today, these adult sons were not expected to play a caregiving role and so were not taught how to nurture. Not feeling comfortable in a caregiving role, and already uneasy about nurturing their children, these fathers may experience more guilt about how much or how well they were caring for their ailing parent.

Education is also an important predictor of guilt for men caregivers. Regression results showed that men caregivers with some postsecondary education were more likely to suffer from high levels of guilt than those who had not finished high school. These men had guilt index scores 14% (0.29 points on the two-point guilt index) higher than those with less than high school.

Regression results indicated that the guilt index scores of men caring for a woman were about 10% (0.20 on the two-point guilt index) higher than those of men caring for a man. Chart 4.15 illustrates that men have substantially more guilt when providing personal care to a woman other than their wife or to another man. It may be that men understand the needs of their spouse because of their close relationship, and of other men because of their shared gender, but feel quite uncomfortable when trying to meet the needs of other

women, such as a mother or sister. A lack of understanding and some embarrassment in providing personal care to such women appears to lead to high levels of guilt.

Guilt is alleviated when men devote more time to caregiving. According to regression results, with each additional hour spent on caregiving, men's guilt index scores declined by about 1% (0.016 on the two-point guilt index). Clearly the more time individuals spend caregiving, the less likely they are to feel they should be doing more.

Gender differences in guilt

Generally, men were somewhat more likely to feel guilty about their caregiving activities than were women. Regression analyses, run separately for women and men, disclosed three common predictors of guilt: age of the caregiver; presence of children under 15; and education. The rank order of these predictors was the same, but the absolute rank differed somewhat.

While age was negatively related to guilt for both women and men, it was the most important predictor for women and second to labour force status for men.⁷ Age likely brings greater competence in carrying out the caregiving role and reduces the basis for guilt. For men, differences in socialization between cohorts likely reinforce this effect.

The presence of children, which ranked third for women and fifth for men, had the opposite effect on guilt for women and men. Women with children felt less guilty about the amount and quality of their eldercare than childless women, while men with children felt guiltier. Part of the explanation for this may be the different societal expectations related to nurturing roles of women and men. "Paid work is seen as primary for men and caregiving is seen as primary and natural for women." (Walker et al. 1989). Mothers, comfortable with the nurturing role and having gained more experience with their children, may experience less guilt when extending their caregiving role to include seniors. For fathers, however, additional caregiving responsibilities may lead to a greater sense of guilt.

Education, which ranked fourth for women and sixth for men, was positively related to guilt for both women and men. The more time respondents had spent on formal education, the more likely they were to be engaged in a demanding professional or managerial career that is less accommodating to family demands such as eldercare. Such individuals may also be more likely to hire help for the senior rather than do the work themselves and may feel guilty about "abandoning" what they, and others, see as their responsibilities.

Also among the top indicators of guilt for women were whether they were the primary caregiver and whether they felt close to the elder recipient, factors closely related to nurturing and compassion. In contrast, labour force status and the number of people helped, factors that tend to be related to competing demands, were the other important indicators of guilt for men.

Much has been written about the socialization process and societal expectations of women and men. Clearly gender roles contribute to the differential guilt burden experienced by women and men. With a less gendered division of labour, when both men and women feel comfortable in a caregiving role, the guilt gap between men and women may diminish.

⁷ Statements about relative importance of predictors also are reflected in the relative amount of variance explained by predictors.

Table 4.8
Burden

	Women	Men	Total
	% of caregivers responding affirmatively		
Looking back over the past 12 months...			
a) has helping others caused your health to be affected?	27.5	10.6	20.8
b) do you feel that because of the time you spend helping people you don't have enough time for yourself?	45.1	35.5	41.3
c) do you feel stressed between helping others and trying to meet other responsibilities for your family or work?	59.4	44.7	53.6
d) do you feel angry when you are around the person(s) you are helping?	25.2	19.4	22.9
e) do you wish that someone else would take over your caregiving responsibilities?	37.3	34.0	36.0
f) do you feel burdened in helping others?	18.9	17.0	18.2

Source: Statistics Canada, General Social Survey, 1996.

Burden

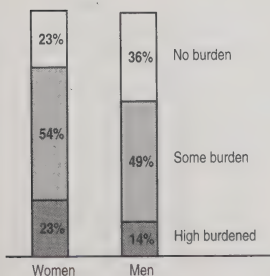
Burden was measured in the survey by six questions related to psychological, emotional and physical hardships: believing your health to be affected; feeling you don't have enough time for yourself; feeling stressed by trying to meet competing responsibilities; feeling angry around the person you are caring for; wishing someone else would take over the caregiving; and perceiving the overall amount of burden arising from caregiving.

As Table 4.8 shows, both women and men most frequently reported feeling stressed trying to meet both their caregiving and other responsibilities. They also often felt that they didn't have enough time for themselves and wished someone else would take over their caregiving responsibilities. There were statistically significant gender differences in the proportion responding affirmatively to all but two of the questions. Similar proportions of women and men reported wishing someone else would take over and feeling generally burdened by caregiving. However, greater proportions of women than men responded

affirmatively when asked whether their caregiving responsibilities had affected their health; the time they had for themselves; created role conflict; and anger toward the care recipient. Of particular note is the observation that almost three times as many women as men reported that their health had been affected. Also of interest is the low proportion of caregivers who reported feeling generally burdened by their caregiving responsibilities relative to the proportion who reported experiencing individual physical or psychological consequences.

Chart 4.16

Eldercare creates a bigger burden for women than men



Source: Statistics Canada, General Social Survey, 1996.

Aggregating responses to these questions produced an index measuring the level of psychological and physical hardship arising from taking on caregiving responsibilities. Women were generally more burdened by their caregiving responsibilities; they scored an average of 2.1 on the six-point burden scale, while men's scores averaged 1.6. Chart 4.16 further illustrates the gender differences in burden scores. Just 23% of women did not feel burdened compared with 36% of men. Similar proportions were moderately burdened (indicated by affirmative answers for one to three of the six questions), while 23% of women compared with 14% of men felt highly burdened (reflected in affirmative responses for four or more of the questions).

Significant predictors of burden

As with other consequence indices, regression analyses were used to identify those caregiver, care recipient, dyad and care characteristics that are significant predictors of the level of burden experienced by eldercare providers. The reduced models, showing which characteristics are significant predictors for men and women and the order in which they enter the regression analysis, appear in tables 4.9 and 4.10.

Women

For women, the factors that best predict the level of burden arising from caregiving responsibilities, in order of significance, included: the type of relationship; the number of

people she helps; the senior's age/degree of frailty; the quality of the relationship; the time spent on caregiving per week; and the caregiver's labour force status.

The most important of these predictors is the caregiver's relationship to the senior. As Chart 4.17 shows, daughters reported the highest level of burden—30% of women caring for parents responded affirmatively to four or more of the questions that comprise the burden index. The level of burden generally declines as the relationship between the caregiver and care recipient becomes more distant, suggesting that it is more psychologically and physically challenging to care for those to whom you are most closely related, and toward whom you probably feel the greatest obligation to care. The least burdened were friend caregivers, only 10% of whom scored four or higher on the burden index. Similarly, the regression results reported in Table 4.9 show that women caring for parents report scores that are, on average, about 10% (0.58 points) higher on the six-point burden index than their counterparts who are caring for their husbands. Women caring for friends, on the other hand, report lower burden index scores (13% or -0.72 points) than spouse caregivers. It is likely that wives perceive the things they do for their husbands as part of their normal routine rather than as care or help. They may even have expected to be called on to provide care to a frail or ailing spouse at some point in their lives and were most likely socialized not to think of these responsibilities as burdensome. Caring for a parent, while still obligatory, is more likely to be unexpected, and the role reversal involved, coupled with the distress of observing the physical and/or cognitive deterioration of a parent, may be harder to cope with. In sharp contrast, caring for friends is more likely to be purely voluntary and less likely to invoke feelings of loss because of their deteriorating health. As a result, caring for friends is perceived to be less burdensome than caring for a husband.

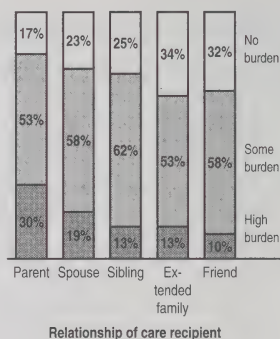
Women also feel a greater burden as the number of people they are caring for increases. Regression results showed that women's burden index scores increased by 3% (0.19 points) on the six-point burden index for each additional person. It is likely that the more people one cares for, the more difficult caregiving becomes, because of divided attention, loyalties and increased competition for limited time and energy resources. Further, fully 41% of women were caring for three or more people, making high proportions of female caregivers vulnerable to higher levels of burden.

Age/degree of frailty of the care recipient is also an important predictor of burden for women. As Chart 4.18 shows, women caring for someone who subsequently died were much more likely to experience a high level of burden than were those caring for still-living seniors of any age. Regression results also showed that women who had been caring for someone who died within 12 months of the survey felt 11% (0.65 points) more burdened than those caring for a still-living senior aged 65 to 74. Care provided to a senior who subsequently died was most likely to have been palliative care. Caring for a close relative or friend who is dying may be more difficult to cope with than assisting someone with a chronic, but not life-threatening, condition.

Women who felt that they had a poor-quality relationship with the person for whom they were caring reported the

Chart 4.17

Women are least burdened by caregiving for friends



Source: Statistics Canada, General Social Survey, 1996.

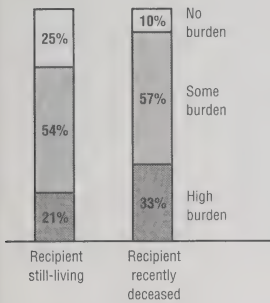
Table 4.9
Burden Consequences of Caregiving Canadian Women, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	0.948**
Relationship – parent	0.579**
Number of people cared for	0.187**
Age/frailty – deceased	0.649**
Quality of relationship – not close	0.822**
Relationship – friend	-0.717**
Weekly hours of care	0.023**
Labour force status – full-time	0.382**
F = 17.731	
R square = 0.141	
** p<0.01	
* p<0.05	

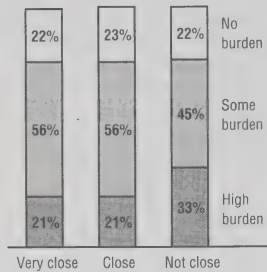
Source: Statistics Canada, General Social Survey, 1996.

Chart 4.18

Caring for dying creates the highest burden for women

**Chart 4.19**

Quality of eldercare relationship affects burden for women

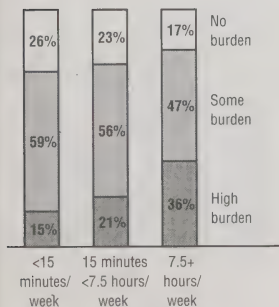


highest level of burden. As Chart 4.19 illustrates, a much higher proportion of women who said the quality of their relationship was "not close" reported a high level of burden (33%) than women who said their relationship was either "very close" or "close" (21% each). Similarly, regression results indicated that, even after controlling for a variety of other factors, women who did not feel close to the person cared for were 14% more burdened (0.82 points on the burden index) than those who perceived their relationship to be very close. It is not surprising that a caregiver would feel more burdened by having to care for a friend or relative with whom they do not share a close relationship than by caring for someone they feel close to.

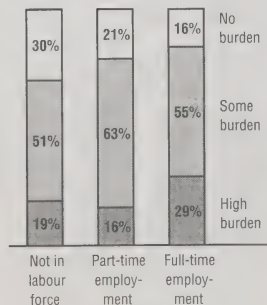
Time spent caregiving was positively associated with the level of burden reported by women. As Chart 4.20 shows, women who spent 7.5 hours or more a week caring for a senior friend or relative were much more likely to report high levels of burden than those who spent less time per week on eldercare. Regression results also reflected this positive association between time spent caregiving and burden: burden scores increased by 0.3% (0.02 points) for each additional hour per week of eldercare. It is to be expected that the more time caregivers spend caring for a senior relative or friend, the less time they will have for themselves or for meeting competing family or employment demands, and the greater the likelihood that their multiple demands will affect their health, their attitude toward the people they are caring for, and their need for assistance.

Chart 4.20

Increased time on eldercare brings increased burden for women

**Chart 4.21**

Full-time employment increases number of highly burdened women caregivers



Finally, women employed full time reported much higher levels of burden than did women not in the labour force or women employed part time. As Chart 4.21 illustrates, more full-time employed women (29%) than non-employed women (19%) reported being highly burdened by their caregiving responsibilities, responding positively to four or more of the six items comprising the burden index. According to regression results, women employed full time reported scores that were about 6% (0.38 points) higher on the six-point burden index than their counterparts who were not in the labour force, but women employed part time were not significantly different from non-employed women. Employment competes with other demands on the caregiver's time and attention, and it isn't surprising that full-time employed women are more likely to feel that their caregiving responsibilities leave them with insufficient time for their other responsibilities or for themselves. Regression results indicated that burden scores of non-employed and part-time employed women were comparable, while those of full-time

Source: Statistics Canada, General Social Survey, 1996.

employed women were significantly higher. This suggests that part-time employment is more easily managed by caregivers than full-time employment. Full-time and part-time employment differ not just in the number of hours the employee is expected to be present in the workplace, though this is probably an important determinant of the ease with which one can juggle competing demands. Indeed, many women report choosing part-time over full-time employment so as to be better able to meet family demands (Logan 1994). However, part-time jobs also tend to be more casual and less demanding in nature than full-time jobs (Schellenberg 1997). It is likely that all these differences contribute to reported differences in burden scores.

Men

Results of regression analysis reported in Table 4.10 showed the statistically significant predictors of burden for male caregivers, in order of significance, included: labour force status; geographic proximity; time spent on caregiving; number of persons helped; relationship of respondent to care recipient; respondent's education; and the length of time the respondent has been providing care.

Like women, men who were employed part time or were not in the labour force experienced the lowest levels of burden. As Chart 4.22 shows, 6% of men who were not employed and even fewer who were employed part time reported they were highly burdened, responding positively to four or more of the six items that make up the burden index. In contrast 19% who were employed full time reported a high level of burden. This observation was also reflected in results of the regression analysis. Full-time employed men's scores were about 12% (0.72 points) higher on the six-point burden index than men who were not employed. Men, like women, probably find it more difficult to manage eldercare on top of full-time employment and so find it more emotionally and physically burdensome.

Geographic proximity, which had no impact on women's burden index scores, is an important predictor of the level of burden experienced by male caregivers. Chart 4.23 suggests an interesting pattern. Generally speaking, male caregivers living closest to the senior for whom they are caring seemed to be the least burdened, while those living at a moderate distance are the most burdened. Results of the regression analysis indicated a similar pattern. Burden index scores for male eldercare providers living in the same general area as the senior, or less

Table 4.10
Burden Consequences of Caregiving Canadian Men, 1996
Reduced Regression Model

Predictor	Coefficient
Constant	0.223
Labour force status – full-time	0.719**
Proximity – <1/2 day away	0.636**
Weekly hours of care	0.038**
Proximity – surrounding area	0.356*
Number of people cared for	0.151**
Relationship – parent	0.400**
Education – trade school/community college	0.331*
Length of time caregiving	-0.431*

F = 11.858

R square = 0.164

** p<0.01

* p<0.05

Source: Statistics Canada, General Social Survey, 1996.

Chart 4.22

Full-time employment also increases number of highly burdened men caregivers

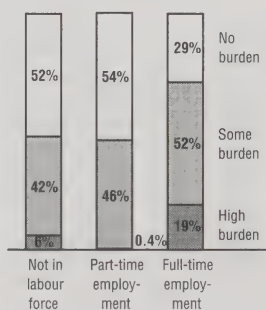
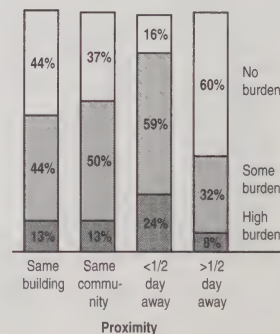


Chart 4.23

Geographical proximity to the care receiver affects the proportion of highly burdened men



Source: Statistics Canada, General Social Survey, 1996.

than a half day away, were 6% (0.36 points) and 11% (0.64 points), respectively, higher than those of men who lived with the senior. The greater the distance the caregiver lives from the care recipient, the more commuting time is involved and the greater the difficulty of monitoring the senior is likely to be. This, in turn, probably means greater anxiety about the senior's well-being. As a result, caregiving at a distance is more emotionally and physically burdensome than caring for a co-resident senior.

Men who spend more time caring for seniors also have higher burden index scores. Regression results indicated that burden scores were 0.7% (0.04 points) higher on the six-point burden index for every additional hour men spent on eldercare. Not surprisingly, and as with women, a larger caregiving load is associated with higher levels of burden since care time reduces caregivers' ability to attend to the needs of their paid work, their own well-being or other family members.

For similar reasons, men who care for more people also experience higher levels of burden. More than three-quarters of men caring for three or more people reported moderate to high levels of burden, compared with 53% of those caring for only one or two. According to regression results, men's burden index scores increased by 2.5% (0.15 points) on the six-point burden index for every additional care recipient. Like care time, the number of seniors cared for is an indicator of the size of the respondent's caregiving load. It may, in addition, be an indicator of the extent to which the caregiver's time and attention is fragmented. Both characteristics are likely to impinge on the caregiver's ability to cope with other demands and so increase emotional and physical stress.

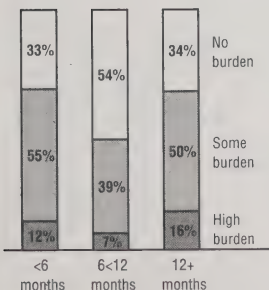
How the caregiver is related to the care recipient is also an important predictor of burden for men. Parental care is associated with the highest level of burden for men, as it is for women. Less than 10% of men caring for spouses, siblings, extended family or friends reported a high level of burden (as indicated by affirmative responses to at least four of the six items composing the burden index), compared with more than double the proportion (21%) of those caring for parents. Similarly, regression results indicated that men caring for a parent reported burden index scores 7% (0.40 points) higher than those caring for their wife. It is likely that we do not view the things we do for our spouses as unusual or onerous, but rather as a natural part of our relationship with them. In contrast, the traditional caring relationship shifts when we begin to care for our parents. There may be underlying power/control issues with which to cope when parents reluctantly become dependent on their adult children for support. We do not necessarily anticipate caring for our parents, and doing so is often fraught with difficulties, associated as it is with deteriorating health. Parental care, therefore, can be more distressing than spousal care.

Education was also associated with burden. Regression analysis suggested that male respondents with a diploma or certificate were more likely than those who had not completed high school to experience greater burden. Caregivers who had completed trade school or community college reported burden index scores 6% (0.33 points) higher than caregivers who had less than a high school education. Men with a diploma or certificate are more likely to be employed in professional trades than are high school dropouts. Such jobs may make it more difficult to balance competing responsibilities and find time for one's self, subsequently adding to health problems and resentment toward the care recipient and/or others who could be helping.

The final important predictor for men is the length of time they have been providing care. As well as having less guilt, men who have been providing care for six to 12 months are less burdened than men who have been providing care for less time. Chart 4.24 illustrates the regression results. Two conflicting factors may underlie the seeming paradox

Chart 4.24

Length of time spent caregiving affects burden for men



Source: Statistics Canada, General Social Survey, 1996.

demonstrated in the chart. After six months, men have had time to develop the skills necessary to handle the caregiving needs of the ailing senior more competently. More experience appears to explain the significantly lower level of burden for men who have been providing care for a period of from six to 12 months. For periods extending beyond one year, the increasing frailty of the elder may more than offset the advantages of being more capable and proficient. The proportion of males who have been providing care for more than one year again rises to previous levels. Regression results also indicated that only men who had been caring for the senior for between six and 12 months reported lower levels of burden — 7% (0.43 points) — on the six-point burden scale than those who had recently begun caring.

Gender differences in burden

Male and female eldercare providers shared three of the five most important predictors of burden, but they ranked somewhat differently. Greater caregiving demands, in the form of more hours of care and caring for more people, were associated with higher burden for both men and women. Similarly, both men and women who were caring for a parent had higher burden scores than their counterparts who were caring for a spouse, though the impact was somewhat greater for women (0.58) than for men (0.40).

Perhaps of greater interest is how the top predictors differ for men and women.⁸ For men, labour force status, geographic proximity, weekly hours of care and the number of people they were caring for were the top four predictors. Men appear to react more strongly to factors that place added demands on their time and energies. The number of people cared for and the weekly hours of care were also among the top five predictors of women's burden. However, how they are related to the senior, the senior's age and frailty, and the quality of their relationship with the senior have greater impact. That is, in contrast to men, they appear to be most strongly affected by the nature of their relationship with the person they are caring for rather than the demands on their time and energy.

Employment consequences—job adjustments

The index of job adjustments comprises four questions relating to changing hours of work, coming late or leaving early, missing a day or more of work, and having job performance affected. Only respondents who were employed were asked to answer these questions. As a result, the sample is smaller (669) than for the preceding analyses.

As Table 4.11 shows, helping others has caused employed caregivers to make adjustments to their paid work. Absenteeism—both partial (arriving late to work or leaving early) and full (missing a full day or more of work)—was the most common job adjustment reported. Over one-third of men and women reported missing partial days of work and almost as many (28 to 32%) missed a full day or more. Significant minorities also reported that they had had to change their hours of work because of their caregiving responsibilities, or that their job performance had been affected.

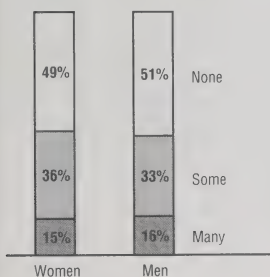
Table 4.11
Job Adjustment Items

	Women	Men	Total
% of employed caregivers responding affirmatively			
Looking back over the past 12 months, has helping others caused you ...			
a) to change your hours of work?	17.7	21.9	19.6
b) to come late to work or leave early?	35.9	37.2	36.4
c) to miss a day or more of work?	31.7	27.8	30.0
d) affected your job performance?	17.1	16.1	16.6

Source: Statistics Canada, General Social Survey, 1996.

⁸ Statements about relative importance of predictors reflect both the order in which predictors entered the stepwise regression and the relative amount of variance explained by predictors.

About 15% of employed caregivers experience many job adjustments



Having a child increases a woman's chance of experiencing job adjustments

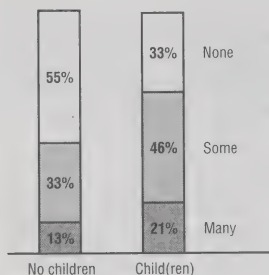


Chart 4.25 shows that caregiving responsibilities are likely to cause slightly more women than men to make adjustments to their paid work. Similar proportions of women and men (15% and 16%, respectively) made many adjustments because of their caregiving responsibilities. However, 36% of women and 33% of men made some adjustments, while 49% of women and 51% of men made no changes in their employment in response to caregiving demands.

Stepwise regression analysis, using scores on the job adjustment index as the dependent variable, was used to identify significant predictors of job adjustment index scores. The reduced models for women and men appear in tables 4.12 and 4.13, respectively.

Regression results (Table 4.12) indicated that the significant predictors of women's job adjustment index scores included, in order of importance: the presence of children under age 15; labour force status; the age/degree of frailty of the care recipient; the educational level of the caregiver; and the relationship of caregiver to the care recipient.

As shown in Chart 4.26, 21% of women caregivers who had children under age 15 living at home made three or more job adjustments as compared with only 13% of women without children under age 15. Table 4.12 also showed that women with children under age 15 scored about 14% (0.55 points) higher on the four-point job adjustment index than those without children under the age of 15. Children represent competing demands for women. More time and energy demands are involved in caring for children in addition to maintaining a career and providing eldercare. There also is greater potential for schedule conflicts, which may result in tardiness, absenteeism and poor job performance.

Reduced Regression Model

Predictor	Coefficient
Constant	0.350*
Presence of children <15	-0.553**
Labour force status – full-time	0.502**
Age/frailty – deceased	0.567**
Education – trade school/community college	-0.354**
Relationship – parent	0.288*

F = 9.287
R square = 0.118

** p<0.01
* p<0.05

Source: Statistics Canada, General Social Survey, 1996.

Regression results also indicate that women working full time scored about 13% (0.50 points) higher on the job adjustment index than women working part time. When more hours are spent doing paid work, women are more likely to have greater difficulty meeting the simultaneous demands of eldercare, such that absenteeism, tardiness and changes in work schedules are required. Similarly, greater fatigue and worry may affect job performance.

Women who cared for an elderly individual who later died scored 14% (0.57 points) higher on the job adjustment index as compared to those women caring for an elderly individual aged 65 to 74. It is likely that seniors who died during the 12 months preceding the survey required intense palliative care that interfered significantly with their attendance, punctuality and concentration on their job.

Regression analysis also showed that women with trade school diplomas or community college degrees had scores about 9% (-0.35 points) lower on the job adjustment index as compared with those women with less than high school education. Women with less than high school education are more likely to have blue-collar occupations (Mutscher 1994), which often generate lower earnings than women with trade school and community college degrees. Perhaps those with lower earnings perceive the opportunity costs arising from job adjustments to be less than do those with higher earnings. Work schedules for blue-collar jobs may also be less flexible than in the professional trades: meeting eldercare demands may require blue-collar workers to take time off, while those employed in the trades may be able to rearrange work schedules to accommodate the demands.

Women caring for a parent also scored 7% (0.29 points) higher on the job adjustment index, compared with women caring for a spouse. Spouses doing care tasks for their partners may not view their assistance as "care" but merely as an extension of the normal exchange of assistance between spouses. Conversely, caring for a parent may be perceived as unusual and unexpected, even uncomfortable, thus more difficult to cope with in conjunction with employment responsibilities. Further, those caring for senior spouses are likely to be seniors themselves and so approaching retirement. They may, therefore, be less attached to their job, or be employed in a senior position with greater time flexibility, and so be more willing, or able, to be tardy or absent in order to care for their spouse.

Men

In contrast to women, regression results (Table 4.13) showed that important predictors of men's job adjustment index scores included: whether they provided personal care to the recipient; the presence of children under 15; geographic proximity; labour force status; and the quality of the relationship between caregiver and care recipient.

As shown in Chart 4.27, 30% of men who provided personal care to the care recipient made three or more job adjustments, while only 13% of men who were not providing personal care did so.

This relationship was further illustrated in the regression results, which showed that men who were providing personal care scored about 15% (0.60 points) higher on the job adjustment index than those who were not

Table 4.13
Job Adjustments Consequences of Caregiving Canadian Men, 1996

Reduced Regression Model

Predictor	Coefficient
Constant	0.266
Personal care	0.597**
Presence of children <15	0.405**
Proximity - <1/2 day away	0.546**
Labour force status - full-time	0.561*
Quality of relationship - not close	-0.363*
F = 9.606	
R square = 0.147	
** p<0.01	
* p<0.05	

Source: Statistics Canada, General Social Survey, 1996.

Chart 4.27

Providing personal care increases job adjustments for men

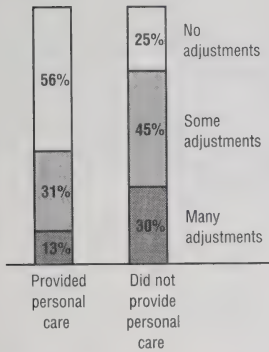
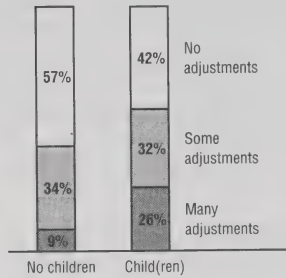


Chart 4.28

Men with children also experience more job adjustments



providing personal care. Personal care requires more time and energy, is less flexible, and involves a higher number of crises (CARNET 1993; Gottlieb et al. 1994; Martin Matthews and Campbell 1995) than other types of care. The intimate nature of tasks such as bathing, dressing, feeding and toileting also makes this type of care emotionally and psychologically difficult. It comes as no surprise, then, that men who provide personal care are more likely than those who do not to be tardy, absent and distracted at work.

Twenty-six percent of men with children under age 15 made three or more job adjustments as compared with only 9% of men without children under age 15 (see Chart 4.28). These findings were supported by the regression results, which showed that men with children under age 15 had job adjustment scores that were about 10% higher (0.41 points) than men without children under age 15. Child care demands compete with eldercare and employment demands for the employed caregiver's time and energy. This "triple whammy" might be expected to result in tardiness, absenteeism, poor job performance and the need to reschedule paid work responsibilities to accommodate family demands.

Source: Statistics Canada, General Social Survey, 1996.

Geographic proximity was found to play a major role in whether men made job adjustments. Male caregivers who lived less than a half day away from the senior care recipient scored about 14% (0.55 points) higher on the job adjustment index than men who lived in the same household or building as the senior. Residing outside the same city but less than a half day away likely results in increased travel time, and this further increases the potential for time conflicts.

Men employed full time had job adjustment index scores about 14% (0.56 points) higher than men working part time. Because more hours are spent in paid work, men working full time have less time to balance paid work and eldercare demands than those in part-time employment.

The quality of the relationship between the caregiver and care recipient also was found to be a pivotal factor in men's job adjustment scores. Men who were not close to their care recipient scored lower—by about 9% (0.36 points)—on the job adjustment index than men who were very close to their care recipient. Employed caregivers who feel close to the care recipient may be more willing to make adjustments to their paid work to care for that person because of the greater reward derived from helping a person to whom they feel close.

Gender differences on job adjustments

Overall, slightly greater proportions of women than men made job adjustments and, while men and women shared some predictors of job adjustments, other predictors were unique to each gender.

Both women's and men's job adjustments were significantly influenced by competing demands, such as child care and full-time employment. The substantial time commitments connected with the three competing roles, coupled with a high potential for scheduling conflicts, quite logically seem to be associated with a higher likelihood of both male and female caregivers having to change their hours of work, miss full or part days of work, and/or exhibit poorer job performance.

Other significant factors in women's and men's job adjustments were related to the intensity of the needs of the care recipient. The strongest predictor for men's job adjustments was providing personal care, and the third most important for women was the frailty of the care recipient. These factors are associated with poorer functional status and more intense and immediate needs of the senior care recipient. The resulting greater caregiving demands increase the likelihood of schedule conflicts and unmanageable time and energy demands.

Postponed educational and employment opportunities

The postponed opportunities index comprises three questions about whether respondents had postponed such economic opportunities as education, job transfers/promotions and job offers because of their caregiving responsibilities.

As Table 4.14 indicates, 8% of women and 6% of men reported having postponed educational plans. A similarly small proportion of women also reported having turned down a job transfer/promotion (6%) or job offer (4%). Even fewer men (2%) reported having done so. While helping others caused small proportions of women and men to postpone economic opportunities, women were two to three times more likely to do so than men.

Aggregating responses to these three questions produced an index measuring the number of opportunities respondents had postponed. As shown in Chart 4.29, almost twice as many women (12%) as men (7%) had postponed one or more economic opportunities.

Significant predictors of postponed economic opportunities

Regression analyses, this time using scores on the postponed opportunities index as the dependent variable, were once again used to identify significant predictors of postponed opportunities index scores. The reduced models for women and men appear in tables 4.15 and 4.16 respectively.

Women

Regression results (Table 4.15) showed that the significant predictors of women's scores on the postponed opportunities index include, in order of importance: the number of people helped by the caregiver; the marital status of the caregiver; whether the respondent provided personal care; the caregiver's employment status; whether the caregiver was primary or non-primary; and whether the caregiver resided in an urban or rural area.

As shown in Chart 4.30, 11% of women caring for one or two people, compared with 14% of those caring for three or more people, postponed at least one educational or employment

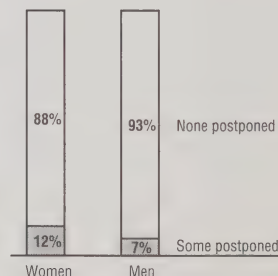
Table 4.14
Postponed Educational and Job Opportunities

	Women	Men	Total
% of employed caregivers responding affirmatively			
Looking back over the past 12 months, has helping others caused you to...			
a) postpone plans to enrol in an educational program?	8.3	6.0	7.3
b) decline a job transfer or promotion?	6.2	2.4	4.5
c) turn down a job offer?	4.2	1.8	3.1

Source: Statistics Canada, General Social Survey, 1996.

Chart 4.29

Women are more likely to postpone opportunities



Source: Statistics Canada, General Social Survey, 1996.

Table 4.15
Postponed Opportunities Consequences of Caregiving Canadian Women, 1996

Reduced Regression Model

Predictor	Coefficient
Constant	-0.279**
Number of people cared for	0.102**
Marital status – separated, divorced	0.256**
Personal care	0.148*
Labour force status – full-time	0.147*
Primary vs secondary caregiver status	0.133*
Rural/urban residence – rural	-0.137*
F = 8.278	
R square = 0.125	
** p<0.01	
* p<0.05	

Source: Statistics Canada, General Social Survey, 1996.

opportunity. Regression results similarly indicated that, with each additional person cared for, scores on the postponed opportunities index increased by about 3% (0.10 points) for women. As the number of seniors being assisted increased, so did the time and energy demands of caregiving, resulting in greater potential for role conflict. Pursuing opportunities that require greater time commitments, such as enrolling in a training program or beginning a new position, are not an option for those with multiple caregiving responsibilities.

Regression results also indicated that marital status influences women's scores on the postponed opportunities index. Separated or divorced women scored about 9% (0.26 points) higher on the postponed opportunities index than women who were married or living common law. Women who are separated or divorced are likely to be shouldering the full responsibility for their own household as well as for eldercare, in addition to their employment roles. Therefore, separated or divorced women may have more demands and less

assistance than women who are married or living common law and so be less able to pursue new opportunities.

Regression results also show that women providing personal care scored about 5% (0.15 points) higher on the postponed opportunities index than those who were not providing personal care. Personal care tasks, including bathing, feeding, dressing and grooming, are more intimate and immediate than other types of tasks and so tend to be more emotionally taxing. As a result, they are also more likely to present scheduling conflicts that discourage the pursuit of new educational or employment opportunities.

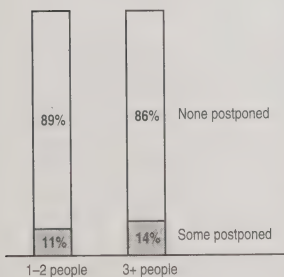
Women who worked full time also postponed more employment and/or educational opportunities than women who worked part time. Regression results indicate that women employed full time scored 0.15 points, or 5%, higher on the postponed opportunities index than women who worked part time. Full-time employment, on top of caregiving responsibilities, apparently imposes constraints sufficient to prevent women from pursuing new employment or educational opportunities.

Women who were primary caregivers also reported postponed opportunities index scores 4% higher (0.13 points) than women who were not primary caregivers. Carrying the primary responsibility for meeting the senior's needs likely makes it more difficult for women to pursue educational or job opportunities.

In contrast, living in a rural region is associated with fewer postponed opportunities than is living in an urban setting. As Chart 4.31 illustrates, 15% of women caregivers who live in urban regions reported postponing one or more educational or employment opportunity, whereas only 5% of those living rural regions experienced these impacts. Regression results also showed that female caregivers living in rural regions scored about 5% (0.14 points) lower than those living in urban settings. Training programs and job opportunities are likely to be more numerous in urban than rural areas. Thus women in urban areas are likely to be presented with more opportunities, which they may then have to reject, as compared with women in rural areas. As well, women in rural areas may be more likely to have extended family in close proximity and therefore have more assistance from others

Chart 4.30

Women caring for 3 or more people are more likely to postpone opportunities



Source: Statistics Canada, General Social Survey, 1996.

in meeting seniors' needs so that when advancement opportunities do present themselves they are more able to take advantage of them.

Men

In contrast to women, important predictors for men's postponed opportunities index scores (table 4.16) include: the hours per week spent caregiving; the number of people helped by the caregiver; and the caregiver's education.

The predictor that had the strongest influence on men's postponed opportunities index scores was the amount of time men spent caregiving. Chart 4.32 illustrates this dramatic difference: fewer than 6% of men who spent less than 7.5 hours per week providing care to the target senior reported having to postpone educational or employment opportunities, compared to 34% of those who provided 7.5 hours or more per week. Similarly, regression results indicated that, for each additional hour per week men devoted to caring for the target senior, the postponed opportunities index score increased by about 1% (0.02 points). Not surprisingly, the heavier the caregiving demands, the less chance men will have to take up such economic opportunities as education, promotions or job offers.

As Chart 4.33 illustrates, men caring for more people also had to forego more educational and employment opportunities. Just 2% of men caring for one or two people reported any postponed opportunities while fully 18% of those caring for three or more did so. Regression results similarly indicated that the postponed opportunities index scores increased by 0.07, or about 2%, with each additional care recipient. Declining job or promotional opportunities may be more necessary when caring for more than one person, as time, energy and management demands are greater.

Men with a high school diploma scored about 5% higher (0.16 points) on the postponed opportunities index as compared with male caregivers with less than high school education. It is likely that those with higher levels of education have greater access to job and educational opportunities than those without a high school diploma such that there would be more opportunities to decline.

Gender differences in postponed opportunities

Women are more likely than men to have to postpone economic opportunities such as education and

Chart 4.31

Urban women are more likely to postpone opportunities

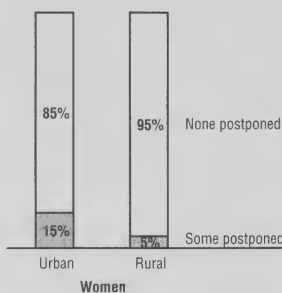
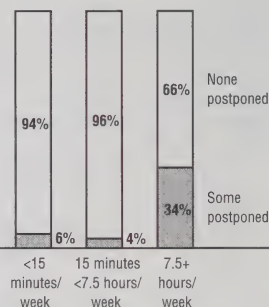


Chart 4.32

Men are much more likely to postpone opportunities if they care for the senior 7.5 hours a week or more



Source: Statistics Canada, General Social Survey, 1996.

Table 4.16
Postponed Opportunities Consequences of Caregiving Canadian Men, 1996

Reduced Regression Model

Predictor	Coefficient
Constant	-0.125**
Weekly hours of care	0.019**
Number of people cared for	0.069**
Education - high school	0.163*

F = 13.244

R square = 0.124

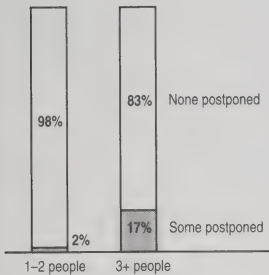
** p<0.01

* p<0.05

Source: Statistics Canada, General Social Survey, 1996.

Chart 4.33

Men are more likely to postpone opportunities if they help more people



Source: Statistics Canada, *General Social Survey, 1996*.

employment opportunities. The predictors of postponed index scores are different for women and men. The only common predictor for both women and men of the need to postpone educational and/or employment opportunities because of caregiving demands was the number of people being helped. The number of people being helped ranked as the most important predictor for women and the second most important for men. Hours of caregiving was the primary predictor for men.

Being separated or divorced was the second most important predictor for women. Perhaps caregiving had strained the marital relationship to the breaking point or the divorced/separated siblings are just expected to have more time to carry out the caregiving duties.

Personal care was the third most important predictor for women. The nature of personal care is intense, draining and inflexible and taking on new challenges such as furthering education and occupation may be difficult when an intense level of care is required.

Women also were influenced by additional indicators of the intensity of caregiving demands and of role conflict such as being a primary caregiver and being employed full time. Each is likely to increase caregiving demands and potential conflict, apparently to the point that they become a deterrent to pursuing new opportunities.

Discussion

This chapter examined how caregivers are affected by their caregiving responsibilities, and the factors that best predict how and the extent to which they are affected. Many of the same consequences of caregiving explored in prior research were revealed in this study, including impacts on caregivers' physical, social, emotional, psychological and economic well-being. Unlike previous studies, though, which have tended to examine only one or two of these consequences at one time, the results reported here allow us to examine patterns across a wide spectrum of consequences. Moreover, examining predictors of different types of consequences provides evidence about which caregivers are most at risk and hints at actions that policy makers and practitioners could take to reduce that risk.

What are the consequences of caregiving?

The few indicators of positive outcomes of caregiving that were available to us suggest that both men and women regard caregiving as rewarding. Caregiving appears to provide an opportunity to reciprocate for help received from others and to strengthen personal relationships.

Far more was learned, though, about the problematic aspects of caregiving. The most commonly experienced consequence for both women and men caregivers was guilt. More than half of caregivers felt they should be doing more for others, or could be doing better. Interestingly, men appear to be somewhat more subject to these guilty feelings than women. Historically, caring for family members has been regarded as the natural role of women. More recently, however, societal attitudes are changing in such a way that men are increasingly expected to participate in caregiving. Women's increased participation in paid work puts further pressure on men to take more responsibility for meeting family needs. As yet, though, these attitudinal changes have not translated into equity with respect to the actual division of responsibility for family care: women remain the primary caregivers for both children and dependent adults. Perhaps men feel guilty for good reason about their involvement in, or competence at, caregiving.

Social and psychological consequences were also relatively common for both men and women. Between one-quarter and one-half of caregivers reported the need to change social and holiday plans, and said they lacked time for family and self. This is consistent with prior research, which also has suggested that this social isolation and lack of “me time” can translate into increased stress and decreased life satisfaction (see, for example, White-Means and Chang 1994).

On the whole, however, women appear to be more affected by their caregiving responsibilities than do men. Female caregivers reported more physical consequences, such as changes in sleep patterns in their own health. This raises concerns about caregiver burnout, especially for women. Women are also likely placed at greater economic risk by their caregiving activities. First, women were more likely than men to report feeling stressed by the multiple demands of family caregiving and paid work. Not surprisingly, then, they also were more likely than men to report such employment consequences as tardiness, absenteeism and poorer job performance. Further, while few caregivers reported postponing educational or job opportunities such as promotions or job offers, more women than men did. The long-term financial implications of such consequences should be of grave concern. While women’s labour market opportunities, and hence their economic security, have improved significantly in recent decades, women are still disadvantaged in the job market. The results of this study suggest that the growing demand for eldercare, and the increasing caregiving load for women that results from it, could take its toll on women’s employment opportunities and their economic well-being. The failure of continuing care and labour market policy to respond to these new challenges may well mean that women risk losing some of their recently gained ground.

What are the predictors of the consequences of caregiving?

Table 4.17 summarizes the caregiver, care recipient, dyad and care characteristics that predicted the extent to which caregivers experienced various types of consequences. The best predictors—those that were significant predictors of most consequences for men and women—included: relationship; labour force status; the number of people cared for; and geographic proximity. While Chapter 3 showed that spouses spent the most time providing care, those caring for parents tended to experience the greatest consequences, holding other factors constant. Sons caring for parents experience higher levels of social and psychological consequences, while daughters reported more job adjustments, postponed opportunities, socioeconomic consequences and burden.

Not unexpectedly, competing demands such as full-time paid work and multiple caregiving responsibilities generally increased the severity of social, psychological and employment consequences. It should be noted, however, that part-time employment was rarely a significant predictor. That is, caregivers working part time were no more likely than those not employed to experience social or psychological consequences. This is consistent with research showing that part-time employment is often chosen as a strategy for meeting competing paid work and family demands more comfortably (Logan 1994).

Distance also added to caregivers’ hardships, but in a somewhat unexpected way. Those living at a moderate distance—less than a half day’s travel away—from the care recipient were most likely to report that their caregiving responsibilities affected their social lives, their psychological well-being and their employment. These caregivers probably lived close enough to be expected to help, but far enough away to find the commute stressful and time consuming.⁹

⁹ It should be noted that commuting time was not included in the estimate of time spent caregiving.

Table 4.17
Predictors of Consequences of Caregiving by Type of Independent Variable

Predictor	Women	Men
Caregiver characteristics		
Age	Postponed opportunities, guilt	Guilt
Education	Job adjustments, socioeconomic, guilt	Postponed opportunities, socioeconomic, guilt
Urban/rural residence	Postponed opportunities, guilt	
Marital status	Postponed opportunities, guilt	
Labour force status	Job adjustments, socioeconomic, burden	Job adjustments, socioeconomic, guilt, burden
Presence of children <15	Job adjustments, guilt	Job adjustments, guilt
Number of people cared for	Postponed opportunities, socioeconomic, burden	Postponed opportunities, socioeconomic, guilt, burden
Care Receiver Characteristics		
Gender	Postponed opportunities	Socioeconomic, guilt
Age/frailty	Job adjustments, socioeconomic, burden	Postponed opportunities
Dyad Characteristics		
Relationship	Job adjustments, postponed opportunities, socioeconomic, burden	Job adjustments, postponed opportunities, socioeconomic, burden
Proximity	Postponed opportunities, socioeconomic, guilt	Job adjustments, socioeconomic, burden
Relationship quality	Job adjustments, guilt	Job adjustments, socioeconomic
Length of time caregiving		Job adjustments, postponed opportunities, guilt, burden
Primary caregiver	Postponed opportunities, guilt	Socioeconomic
Nature of Care Provided		
Weekly hours of care	Socioeconomic, burden, postponed opportunities	Socioeconomic, guilt, burden
Personal care	Postponed opportunities, socioeconomic	Job adjustments, postponed opportunities, socioeconomic

Interestingly, time spent caregiving was generally not an important predictor of whether caregivers' employment was affected by their caregiving, but it did predict whether caregivers experienced social or psychological consequences. The more time female caregivers spent caring for the senior, the greater their socioeconomic and burden consequences. Similarly, men who spent more time caregiving experienced more severe socioeconomic, guilt and burden consequences. Moreover, a significant minority of both men (11%) and women (18%) put in the equivalent of a full work day (7.5 hours) each week on caregiving tasks in addition to their other responsibilities. This suggests that caregivers continue to try to do it all, but at great social and psychological cost.

How long men had been caring for the senior and whether they provided personal care were also good predictors. Experience appears to alleviate the impact of caregiving for men but not for women. This finding is consistent with the notion that, as a result of gender-stereotyped socialization, men are generally ill equipped to assume caregiving roles, but it also suggests that they quickly adapt to these unfamiliar responsibilities. In contrast, providing personal care, perhaps the most demanding and least familiar of all caregiving tasks, was positively associated with the severity of consequences experienced by men. At the same time, a much smaller proportion of men (18%) than women (34%) provided personal care for the senior.

Table 4.18 summarizes the significant predictors of each of the consequences for men and women in a way that permits an examination of the patterns of predictors across consequences and between men and women. Interestingly, the variation in patterns by gender with respect to predictors of consequences was the opposite of that found for predictors of time spent caregiving. In Chapter 3 we observed that, while there was no clear pattern of predominant predictors across all tasks for men, being the primary caregiver emerged as the single most important predictor of time spent doing all care tasks for women. In this case, no one variable stands out as the most important predictor in all

cases for either men or women. However, the set of predictors that best predict consequences was much more consistent for men than for women. Providing personal care, the number of persons helped, labour force status, and how long the respondent had cared for the senior were consistently among the top predictors of consequences experienced by men. Further, the competing demand of full-time employment was the most important predictor of the psychological consequences of guilt and burden, while the demands of the caregiving situation, including whether personal care was being provided and how many people were being cared for, had the greatest impact on employment and social consequences. For women, there was much greater variability in which variables predicted the severity of different consequence and, where a given variable predicted more than one consequence, in their relative importance in different equations.

Table 4.18
Predictors of Consequences of Caregiving

Women	Men
Socioeconomic consequences	
Weekly hours of care	Personal care
Personal care	Number of people cared for
Relationship – parent	Relationship – parent
Age/frailty – deceased	Weekly hours of care
Proximity – <1/2 day	Proximity – >1/2 day
Education – high school	Labour force status – PT>NE
Number of people cared for	Relationship quality – close
Labour force status – FT>NE	Primary caregiver
	Education
	Gender of care receiver
Guilt	
Caregiver's age	Labour force status – LF>NE
Primary caregiver	Caregiver's age
Presence of children <15	Number of people cared for
Relationship quality – close	Length of time caregiving
Education – BA+, diploma	Presence of children <15
Marital status – single	Education – postsecondary
Rural	Gender of recipient
Proximity – >1/2 day	Weekly hours of care
Burden	
Relationship – parent, friend	Labour force status – FT>NE
Number of people cared for	Proximity – same area, <1/2 day
Age/frailty – deceased	Weekly hours of care
Weekly hours of care	Number of people cared for
Labour force status – FT>NE	Relationship – parent
	Length of time caregiving
Job adjustments	
Presence of children <15	Personal care
Labour force status – FT>NE	Presence of children <15
Age/frailty – deceased	Proximity – <1/2 day
Education – diploma	Labour force status – FT>NE
Relationship – parent	Relationship quality – not close
Relationship quality – close	Length of time caregiving
	Relationship – sibling
Postponed opportunities	
Number of people cared for	Number of people cared for
Personal care	Education – HS, postsecondary
Marital status – separated/divorced	Personal care
Relationship – parent	Length of time caregiving
Rural	Relationship quality – not close
Caregiver's age	Age/frailty – 85+
Primary caregiver	
Proximity – >1/2 day	
Gender of recipient	

CHAPTER 5

REPRISE

In Chapter 1 we noted several reasons for the increased interest in the topic of informal eldercare. The first is the perceived demographic imperative associated with an aging population. Since the next cohort of seniors will comprise a larger proportion of the Canadian population, there is a concern that they will require a higher proportion of health and other resources. The second reason—the economic imperative—relates to society's perceived inability to meet the needs of these seniors, given current fiscal restraints linked to deficit- and debt-reduction efforts. Closely related is the familial imperative, which is characterized by a renewed emphasis on families as important supporters of their older members. This rediscovery of families has coincided with a belief that the public costs of care must be reduced.

This chapter addresses these issues by synthesizing the findings presented throughout the book and discussing the policy challenges that arise from them. The focus is on what we've learned about Canada's informal caring needs and resources, and what we see as the likely costs and benefits of increased demands on those resources.

The demographic imperative and the need for informal care

A major source of the concern about eldercare stems from the fact that Canada has an aging population. It is commonly assumed that an aging population will lead to a growing proportion of people with high needs for support, and to an increasing demand on the informal sector to provide this support (Keating, *et al.* 1997). Gee (1995) has called this assumption "demographic determinism." She argues that an aging population has been blamed for the escalating costs of health and social services and for current and projected government deficits.

Is there any support for this assumption? With respect to the informal side of care, our analysis suggests that the demographic imperative may already be upon us. In 1996, the vast majority of seniors received informal assistance of some kind. Further, more than 20% of seniors received assistance because of a long-term health problem. Clearly, there are already high levels of need for both assistance and care among today's seniors. It is also obvious that the informal sector is already highly involved in providing assistance to Canadians of all ages—evidence that Canada is a caring society in which citizens are embedded in networks of friends and kin who help each other. From this perspective, it seems unlikely that an aging population will result in a public sector caregiving crisis, since informal networks will continue to operate to support people of all ages. Given such a high level of commitment from family and friends, we might assume that informal networks will rally to provide support to the increasing numbers of seniors who will need it in the future.

The existence of informal support networks for seniors does not necessarily mean that the informal sector is sufficiently robust to withstand further reductions in formal public sector services. Some seniors are already at risk of not having strong, accessible caregiving networks. And informal support networks may be susceptible to becoming overburdened if demands escalate. Some examples follow.

Findings from Chapter 2 show that those who make up the informal networks of seniors differ in their ability to ensure that seniors' care needs are met. Perhaps the most important member of the network is the spouse. Yet, while most seniors who received assistance with everyday activities were married, only a small percentage said they provided care to (or received care from) their spouse. It may be that, even in the face of a partner's chronic illness, spouses take longer to declare themselves as caregivers or to identify their partner as needing care. The line between assistance and care may well be blurred for those who have a life partner.

Regardless of whether spouses define their help as assistance or care, the presence of a spouse appears to buffer seniors from receiving higher levels of care. Seniors who received assistance because of long-term health problems were more likely to be unmarried than those who received assistance because of "the way things are done" in their households. Similarly, there were higher proportions of unmarried seniors among those in institutional care than among those receiving assistance for long-term health problems in the community.

The caring capacity of spouses is surely a key issue in the debate about society's ability to care for growing numbers of seniors. Not only do spouses carry high caregiving loads, but they are also the least likely of any group of caregivers to ask for assistance from other members of the informal network (Keating, *et al.* 1994). Our findings also suggest that spouses may underreport the care they do provide. The challenge lies in finding ways to provide support to spouses who tend not to reach out for support.

While spouses are clearly an important group of caregivers for contemporary seniors, the largest group of caregivers is made up of adult children. One concern about population aging is that the next cohort of seniors will not have the same access to adult-child caregivers. Because the upcoming cohort of seniors had fewer children than the current one, they will have a smaller pool of adult children to care for them. It is difficult to know whether this will actually reduce the availability of children for caregiving. It may be that children will indeed continue to feel obligated to provide care, but will suffer more consequences since they are less likely to have siblings with whom to share caregiving responsibilities.

As well, when the baby boom generation become seniors, more will have divorced. Little is known about how divorce will affect the caring obligations or caring resources of children. After divorce, adult children may maintain closer contact with one parent. Even if relationships have remained close, complex blended families may require more difficult negotiations concerning caregiving responsibilities and tasks.

The next cohort of seniors will contain a much larger number of people with needs for everyday assistance who may also have needs for care. Both the increased number of seniors in the next cohort and differences in the nature of their immediate family networks mean that tomorrow's seniors may not have the same level of informal support available to them as today's seniors. It is difficult to predict the extent to which the caregiving resources of other informal network members, such as extended family and friends, will compensate for reduced assistance from close kin. Although extended family and friends represent

substantial proportions of current caregivers, their hours of caregiving are relatively low. It seems likely that such informal network members will be more available to provide assistance than to provide intense levels of care.

The familial imperative and the consequences of informal care

Over the past decade there has been a renewed emphasis on informal networks (especially families) as an important source of care for elderly members. The familial imperative is closely connected to the belief that society can no longer afford to provide the same level of public services to the elderly (Gee 1995), and that members of seniors' informal networks must increase their levels of support. A main impetus for the survey on which this book is based was the need for more information on the nature of care provided by informal caregivers.

This section analyses our findings on informal care in order to provide a better understanding of the caring capacity of the informal caregivers who support seniors with long-term health problems. We begin by summarizing what we have learned about Canada's informal caregivers. From this summary, it is evident that caregivers represent a very broad cross-section of Canadians. Next, we discuss relationships between the amounts and types of care provided and examine the impact of this caregiving on care providers. From this analysis, it is evident that women and men experience different caregiving consequences. We then discuss policy initiatives related to these findings with a view to addressing the question of the place that informal caregivers occupy in the provision of support to Canada's seniors.

Who are Canada's informal caregivers? A strong image that emerges from the extensive literature on informal caregiving is one of a middle-aged or older woman, likely a spouse or daughter of the senior recipient, who provides care despite competing obligations created by paid work, marriage or the presence of young children. Although our findings agree with this to some extent, in general we found that caregivers are a much more diverse group than this "typical" caregiver profile suggests.

This study is similar to others in finding that more than half of all caregivers are adult children. In fact, adult children account for over 70% of caregivers between the ages of 30 and 60. The next largest group of caregivers was extended family members such as grandchildren and nieces and nephews. This finding suggests that family caregiving extends well beyond close family members, and that, not only do caregivers span at least three generations, but they also include lateral kin not usually considered part of an obligatory family caregiving network (Keefe and Fancey 1996). Some of these extended family members are primary caregivers (19.4% of female and 15.3% of male extended family caregivers), a finding that suggests that the involvement of some members of this group is more intense than previously thought. Extended family members make up the largest group of caregivers among those aged 15 to 29.

The non-kin segment of the informal caregiving network was the next largest group. There has been a tendency for this group to receive less attention in the caregiving literature, perhaps because of the high level of interest in family caregiving. Yet this is clearly a substantial group, especially among older caregivers. Among male caregivers aged 60 to 74 and female caregivers over age 60, the majority were friends or neighbours of the senior recipient. In fact, more than half of all female caregivers over age 75 were caring for a friend. These findings show that most friend caregivers were the same age or slightly younger than the recipient of care, which underlines the importance of having an existing

friendship network from which to draw caregivers as needed. This points to an area in which the very old are especially vulnerable since the number of same cohort friends is likely to have diminished significantly because of illness and death.

Spouses were proportionately the smallest group of caregivers and seem to be underrepresented, given the amount of literature on their prominence as caregivers. Less than 5% of caregivers were husbands or wives of the person cared for. Spouses may be underrepresented because they are reluctant to state that their spouse has a long-term health problem. This does not mean that tasks are not being done. Results from Chapter 2 showed that the majority of seniors received assistance because of the way things were done in their household. Spouses were the largest group of male caregivers among those aged 75 and older. In contrast, women over age 75 were most likely to be caring for a friend, in part because so many women have outlived their husbands. Small proportions of spouse caregivers do not mean that spouses are not supportive of each other. As well, spouse caregivers far exceed other groups in the average amount of care provided. For example, while spouses provided an average of more than 15 hours per week of care, friends did about two hours. Although they may be relatively few in number, spouse caregivers have the most intense caregiving experiences.

Just as caregivers came from a broad set of kin and non-kin relationships with care recipients, so too were men as well as women actively involved in caregiving roles. Thirty-nine percent of caregivers were men. They differed considerably from women caregivers in the nature of the care they provided. As well, compared with women they provided fewer hours of care to fewer seniors. Nonetheless, their caregiving time was concentrated in tasks that require a daily time commitment: personal care and meal preparation. Men over age 75 reported the highest average hours of care of all caregivers. The majority of these men were caring for their spouse.

Caregivers were also much more broadly distributed across age groups than previously assumed. Although the majority were in their middle years, a substantial minority was under 30. It would be interesting to track these young caregivers across the life course to determine whether those who provide eldercare early in life continue to provide support to other seniors throughout their lives. It may well be that eldercare is becoming a lifelong role for many Canadians. Alternately, it may have been a lifelong role for many Canadians in the past but one that we were unaware of because we neglected to include broad age ranges in our research.

Clearly, there is immense diversity among Canadians who provide informal care to seniors. Thus policy initiatives meant to provide support to caregivers will be most effective if they respond to the needs of these specific constituencies. For example, our findings show that caregivers are just as likely as non-caregivers to be employed and that caregivers do not appear to manage the demands of caregiving by leaving the labour force. It appears that it is not economically feasible for most caregivers to forego employment. Thus employed caregivers may benefit most from family-friendly workplace benefits such as eldercare leave or “flex” time which are aimed at helping employees balance the demands of employment and eldercare.

Another constituency that may require support is older caregivers. In addition to spouses, friends and neighbours are likely to be same-generation peers of the cared-for person. These caregivers might benefit from assistance with transportation to run errands or take the care recipient to appointments. Those providing intensive daily care may benefit from respite services that provide time to meet personal needs for rest or relaxation, a service normally reserved for family caregivers.

There has been a long tradition in the caregiving literature of attempting to understand the issue from the perspective of the caregiver's structural relationship to the care recipient, particularly that of the spouse and adult children. However, as the next section of this analysis will show, other factors such as gender, being a primary caregiver and the type of tasks performed are particularly important in determining the needs of different groups of informal caregivers.

How much caring with what consequences? The extent of caregiving provided by Canadians is evident not only in the breadth of ages and relationship of caregivers to care recipients, but also in the amount of care being provided. In 1996, over two million people aged 15 and over were providing an average of four to five hours of informal care per week to seniors with long-term health problems. A main concern about the familial imperative is that admonitions to the informal sector to do more may place undue pressure on those who are already doing a great deal.

One set of findings that illustrates the involvement of informal caregivers concerns the amount of time spent on various care tasks. These findings reveal the importance of tasks that require daily attention and the differences in characteristics of caregivers who do these tasks. Caregivers' time was not spread evenly across the seven main care tasks. Both women and men spent the highest average hours preparing meals and providing personal care. In some ways these tasks differ substantially. Meal preparation is an activity that is done daily in households regardless of the health status of the occupants. In contrast, personal care to seniors is not part of usual household activity. Perhaps because of this, meal preparation and other daily household tasks are seen as the responsibility of families, even when those tasks are a component of eldercare. Consequently, household support is often given low funding priority among services provided to seniors living in the community (Keating et al. 1997). Personal care is more likely to be given higher funding priority because it is not part of everyday assistance to seniors.

Perceived differences between these two care tasks mask their important similarity: both are essential. Each day, meals must be prepared and served to seniors with long-term health problems. Each day, care recipients must be assisted with personal tasks such as bathing and dressing. These tasks are neither optional nor episodic, and both demand large time commitments from caregivers. Whether or not some of these tasks have been done previously by household members does not make them more or less essential as eldercare.

If informal caregivers are being exhorted to provide more care, it is useful to know what tasks already take a large proportion of their time in order to better understand the nature of support they may need to manage their caregiving activities. The decision about whether a specific task is part of eldercare and whether it should be eligible for public support must be re-examined in light of whether it is essential to maintain the senior at his or her current level of independence, not whether it was previously part of a household's daily activities.

How much can informal caregivers be expected to do? The relationship between the amount of care provided and its consequences sheds light on the question of how much informal caregivers can be expected to do. One of our main findings was that the profiles of caregivers who spent the most time providing care were somewhat different for women and men. For women, being a primary caregiver was the single most important predictor

of the amount of time spent in caring activities. Women who had primary responsibility for care translated that sense of responsibility into active caregiving involvement across all care tasks. Further, the total number of hours that women spent providing care was associated with a number of consequences that included postponed educational or job opportunities, increased expenses, changed social activities, and a feeling of being burdened.

Clearly, primary caregivers who are female carry a heavy load and experience a range of consequences as a result. This suggests that they are vulnerable and need support to help them continue providing care. Policies to support this group of caregivers should be aimed at helping them reduce their overall time commitment or finding ways for the public sector to assume responsibility for some care tasks. These supports are critical in two ways. They may help relieve the consequences of caregiving so that women can maintain their ability to care. They may also reduce the long-term costs of caregiving such as becoming isolated from friendship networks or experiencing a lowered economic status because of increased expenses or employment consequences. It is important to build into policy development a consideration of how we can best prevent today's female caregivers from having unmet care needs when they are old.

For men, being a primary caregiver was the most important predictor of involvement in just two tasks: personal care and home maintenance. Even so, hours spent caregiving were also associated with negative outcomes for men. Providing personal care was particularly problematic, resulting in job adjustments, increased costs, and changes in social life, as well as guilt and burden. Being required to do personal care may be especially difficult for men who are less likely than women to have had experience with such tasks.

For this group, the main policy issue is the need for support to perform unfamiliar tasks. Personal care requires a set of skills and a level of comfort that comes from experience. The fact that men who provide personal care have a variety of negative consequences suggests that these tasks are unfamiliar and difficult for them. One way to support male caregivers might be to help them develop the skills necessary to provide personal care with fewer negative effects. Another is to raise the level of access to publicly funded personal care services to frail seniors living at home. There is evidence that formal support to informal caregivers may enhance their ability to provide care (Edelman and Hughes 1990; Penning and Keating, in press). This support will become even more important as expectations of informal caregivers continue to rise.

Competing demands and caregiving consequences. The data on the impact on caregivers of providing informal care is another source of concern about expecting informal caregivers to do more. Informal caregivers are likely to provide assistance to more than one person and to have additional demands on their time such as employment and other family responsibilities. Given these multiple competing demands, it may be unrealistic to expect that they can or should do more.

An assumption in much of the caregiving literature is that individuals will reduce their caregiving activities in the face of such competing demands. Thus we have long assumed that those who are married, have young children, are employed or have other caregiving responsibilities will manage by reducing their hours of eldercare since they cannot meet the demands of all of these roles concurrently. However, the findings do not generally support this assumption.

For women, being employed, having young children, or caring for more than one person with long-term health problems were generally not associated with lower hours of eldercare. For the most part, women added eldercare responsibilities to the other roles in their lives. This double-duty life was not without its consequences. Women's main strategy for managing multiple demands was to juggle time at work by coming late or leaving early, missing days or adjusting work hours. They did not cope by leaving the labour force altogether.

Men were also unlikely to reduce their hours of care in the face of competing demands. Although men averaged fewer hours of care than women, they reported broader sets of consequences as a result of these demands. Being employed full time resulted in job adjustments, in socioeconomic outcomes, in guilt, and in burden. Having children under age 15 was associated with job adjustments and with guilt, while caring for more than one person led to the postponement of employment and educational plans, to socioeconomic outcomes, to guilt and to burden. The broad set of consequences experienced by men may come from their relative unfamiliarity with some of the caregiving tasks they assumed.

There is little evidence from our analyses suggesting that individuals who assume responsibility for care to frail seniors manage their caregiving by reducing hours of work in other areas of their lives. Both women and men carry multiple demands, although the workloads they carry and the consequences they face differ. The critical point is that providing care to seniors cannot be analysed in isolation since it is part of the context of the multiple areas of paid and unpaid work undertaken by Canadians. The challenge is to develop policy across relevant sectors of interest such as employment and income security, child care, and home care for seniors, with a view to supporting caregivers who face demands in more than one of these areas.

What new challenges have emerged? The picture of the "double-duty life" of caregivers just discussed is an indicator of the strain experienced by caregivers who have high demands on their time in addition to their eldercare responsibilities. There are two other challenges to the caring capacity of the informal sector that emerged from the findings. These relate to the geographic and emotional distances between caregiver and recipient.

The geographic proximity of caregiver to care recipient was a key predictor of caregiver consequences. While those who lived with the recipient reported the highest hours of caregiving, those who lived within commuting distance experienced the most negative consequences. It seems likely that commuting caregivers devoted many more hours to caregiving than were captured by focusing only on care tasks. Missing from the information on time spent were hours devoted to driving back and forth in order to provide care. While living with a care recipient is intense, the distant caregiver clearly has other significant time demands. This group also needs special attention paid to their caregiving stressors. Further information on the types of services provided by these commuting caregivers would provide the basis for informed intervention to reduce the negative consequences of caregiving on them.

A second emerging issue is that of the quality of relationship between caregiver and care recipient. Relationship quality was associated both with hours of care and with caregiving consequences. Female caregivers whose relationship with the care recipient was not "very close" provided fewer total hours of care but were more likely to experience guilt and to make adjustments to their jobs. Similarly, male caregivers with relationships that were less than "very close" also provided fewer hours of care (in home maintenance, shopping, bill paying). They were more likely to experience socioeconomic impacts, but less likely to make job adjustments.

Anecdotal evidence suggests that high hours of care may lead to reduced levels of intimacy between caregiver and care recipient: the caregiver who is busy running errands, preparing meals and providing personal care has little time or energy for activities, such as sitting and talking, that enhance the quality of the relationship. As well, the person caring for someone with dementia is confronted with the loss of the relationship with the cared-for person. It can be difficult to feel close to someone who can no longer respond to shared history. The irony of this situation is that the family imperative assumes that family members are the best caregivers since they know the person best and can provide the most sensitive care. If caregiving has led to a reduction in relationship quality, transferring some caregiving tasks to others might allow the caregiver to maintain a better quality relationship over a longer period of time. Some areas of support to those caring for a relative with dementia might include providing education to help caregivers better understand the nature of the disease, or providing concrete assistance with tasks to reduce caregivers' workload.

In some cases, a less-than-close relationship may have preceded caregiving. In these situations, the enforced contact that comes with providing care to a frail senior may be stressful for both the giver and receiver. Seniors prefer to choose the source of their care. In cases where relationships are poor, the quality of care may suffer.

Optimal support to the caregiver who is distant because of geography or intimacy may take different forms. While the physically distant caregiver may need support to reduce commuting time, the emotionally distant caregiver may need support to reduce face-to-face contact with the recipient without feeling more guilty.

The context, content and consequences of informal caregiving

Evidence from our analyses shows that seniors receive both assistance and care from members of their informal networks. Seniors are much like other Canadians in their receipt of assistance but are more likely than others to receive care. More than two million Canadians provide that care. Their hours of work are equivalent to that of 276,509 full-time employees. They are women and men, old and young, kin and friends. For many, the cost of caring is high. Caregivers add eldercare to other paid and unpaid work. They experience changes in their work lives, their social lives and their economic status. They feel guilt and experience burden. Despite these consequences, the amount of care is impressive. Canadians are actively involved in caring for seniors in need.

Informal caregivers are a precious commodity. They shoulder responsibility for much of the day-to-day assistance given to seniors living in the community. They play a large role in keeping seniors out of institutional care. Yet their capacity to care is already showing signs of strain. We have highlighted some of the specific caregiver constituencies in need of targeted support: caregivers with double-duty lives, commuting caregivers, primary caregivers and spouses. The most important assumption that should underlie caregiving policy for the next century is that these caregivers must not be taken for granted. If we are to remain a caring society, policy instruments and programs must be developed to support these many caregivers in the important work of caring for frail seniors.

REFERENCES

- Abel, E.K. 1990. "Informal care for the disabled elderly." *Research on Aging*. 12: 139-157.
- Abraham, P.Y. and M.L. Berry. 1992. "Needs of the family caregivers of frail elderly." *Canadian Journal of Public Health*. 83, 2: 147-149.
- Angus, D.E., L. Auer, J.E. Cloutier and T. Albert. 1995. *Sustainable health care for Canada*. Ottawa: Queen's University of Ottawa Economic Projects.
- Archbold, P.G. 1983. "Impact of parent-caring on women." *Family Relations*. 32, 1: 39-45.
- Aronson, J. 1992. "Women's sense of responsibility for the care of old people: 'But who else is going to do it?'" *Gender and Society*. 6, 1: 8-29.
- Baillie, V., J.S. Norbeck and L.E.A. Barnes. 1988. "Stress, social support and psychological distress of family caregivers of the elderly." *Nursing Research*. 37, 4: 217-222.
- Barling, J., K.E. MacEwan, E.K. Kelloway and S.F. Higginbottom. 1994. "Predictors and outcomes of elder-care-based interrole conflict." *Psychology and Aging*. 9, 3: 391-397.
- Barnes, C.L., B.A. Given and C.W. Given. 1992. "Caregivers of elderly relatives: Spouses and adult children." *Health and Social Work*. 17: 282-289.
- Barusch, A.S. 1988. "Problems and coping strategies of elderly spouse caregivers." *Gerontologist*. 28, 5: 677-685.
- Blieszner, R. and J.M. Alley. 1990. "Family caregiving for the elderly: An overview of resources." *Family Relations*. 39: 97-102.
- Boaz, R.F. and C.F. Muller. 1991. "Why do some caregivers of disabled and frail elderly quit?" *Health Care Financing Review*. 13: 41-47.
- . 1992. "Paid work and unpaid help by caregivers of the disabled and frail elders." *Medical Care*. 30: 149-158.

- Boyd, M., J. Miller and B. Hughes. 1997. *Power at work: Women and men in management, supervision and workplace planning*. Toronto: Paper presented at the annual meeting of the American Sociological Association.
- Boykin, A. and J. Winland-Brown. 1995. "The dark side of caring: Challenges of caregiving." *Journal of Gerontological Nursing*. 5: 13–18.
- Brody, E.M. 1981. "Women in the middle and family help to older people." *Gerontologist*. 21: 471–480.
- . 1985. "Parent care as a normative family stress." *Gerontologist*. 25, 1: 19–29.
- . 1990. *Women in the middle*. New York: Springer.
- Brody, E.M. and C.B. Schoonover. 1986. "Patterns of parent-care when adult daughters work and when they do not." *Gerontologist*. 26: 372–381.
- Campbell, K.E. and B.A. Lee. 1992. "Sources of personal neighbor networks: Social integration, need or time?" *Social Forces*. 70, 4: 1077–1100.
- Canadian Aging Research Network (CARNET). 1993. *Work and family: The survey*. The Work and Eldercare Research Group. Guelph: Canadian Aging Research Network.
- Cantor, M. 1983. "Strain among caregivers: A study of experiences in the United States." *Gerontologist*. 23: 597–604.
- . 1991. "Family and community: Changing roles in an aging society." *Gerontologist*. 31: 337–346.
- Chapman, N.J., B. Ingersoll-Dayton and M.B. Neal. 1994. "Balancing multiple roles of work and caregiving for children, adults and elders." *Job stress in a changing workforce*. Edited by G. Puryear Keita and J.J. Hurrell Jr. Washington, DC: American Psychological Association, 283–301.
- Chappell, N.L. 1989. "Health and helping among the elderly: Gender differences." *Journal of Aging and Health*. 1, 1: 102–120.
- . 1991. "Living arrangements and sources of caregiving." *Journal of Gerontology*. 46, 1: S1–S8.
- Cicirelli, V.G., R.T. Coward and J.W. Dyer. 1992. "Siblings as caregivers for impaired elders." *Research on Aging*. 14: 331–350.
- Cicirelli, V.G. 1983. "A comparison of helping behavior to elderly parents of adult children with intact and disrupted marriages." *Gerontologist*. 23: 619–625.
- Cochrane, J.J., P.N. Goering and J.M. Rogers. 1997. "The mental health of informal caregivers in Ontario: An epidemiological survey." *American Journal of Public Health*. 87, 12: 2002–2007.

Coward, R.T. and S.J. Cutler. 1989. "Informal and formal health care systems for the rural elderly." *Health Services Research*. 23, 6: 785-806.

Dellasega, C. 1990. "The relationship between caregiving and employment: A study of stress in employed and unemployed caregivers of elderly persons." *The Official Journal of the American Association of Occupational Health Nurses (AAOHN Journal)*. 38, 4: 154-159.

Dowler, J.M., D.A. Jordan-Simpson and O. Adams. 1992. "Gender inequalities in care-giving in Canada." *Health Reports*. 4, 2: 125-136.

Duxbury, L., C. Higgins, C. Lee and S. Mills. 1991. *Balancing work and family: A study of the Canadian federal public sector*. Ottawa: Carleton University, School of Business.

Dwyer, J.W., J.C. Henretta, R.T. Coward and A.J. Barton. 1992. "Changes in the helping behaviours of adult children as caregivers." *Research on Aging*. 14: 351-375.

Dwyer, J.W., G.R. Lee and R.T. Coward. 1990. "The health status, health services utilization and support networks of the rural elderly: A decade review." *Journal of Rural Health*. 6, 4: 379-398.

Dwyer, J.W. and K. Secombe. 1991. "Elder care as family labor: The influence of gender and family position." *Journal of Family Issues*. 12, 2: 229-247.

Edelman, P. and S. Hughes. 1990. "The impact of community care on provision of informal care to homebound elderly persons." *Journal of Gerontology*. 45, 2: S74-S84.

Engelbeen, D.J. 1992. "Family structure and intergenerational exchanges." *Research on Aging*. 14: 427-447.

Ettner, S.L. 1995. "The impact of 'parent care' on female labor supply decisions." *Demography*. 32, 1: 63-80.

Fast, J.E., D. Forbes and N.C. Keating. 1999. *Contributions and needs of informal elder care providers in Canada: Evidence from Statistics Canada's 1996 General Social Survey on social supports*. Edmonton: Report to Health Canada.

Fast, J.E., N.C. Keating, L. Oakes and D.L. Williamson. *Conceptualizing and operationalizing the costs of informal elder care*. Edmonton: Final technical report to the National Health Research Development Program, March 1997.

Finch, J. and J. Mason. 1990. "Gender, employment and responsibilities to kin." *Work, Employment and Society*. 4, 3: 349-367.

Fitting, M., P. Rabins, M.J. Lucas and J. Eastham. 1986. "Caregivers for dementia patients: A comparison of husbands and wives." *Gerontologist*. 26, 3: 248-252.

- Franklin, S.T., B.D. Ames and S. King. 1994. "Acquiring the family eldercare role—influence on female employment adaptation." *Research on Aging*. 16, 1: 27–42.
- Frederick, J.A. 1995. *As time goes by ... Time use of Canadians*. Appendix C. (Statistics Canada Catalogue no. 89-544E). Ottawa: Minister responsible for Statistics Canada.
- Gallagher, D., J. Rose, P. Rivera, S. Lovett and L.W. Thompson. 1989. "Prevalence of depression in family caregivers." *Gerontologist*. 29, 4: 449–456.
- Gallagher, S.K. 1994. "Doing their share: Comparing patterns of help given by older and younger adults." *Journal of Marriage and the Family*. 56: 567–578.
- Gee, E. 1995. "Population aging: A contested terrain of social policy." *Rethinking retirement*. Edited by E. Gee and G. Gutman. Vancouver: Simon Fraser University, Gerontology Research Centre, 13–29.
- George, L. 1987. "Easing caregiver burden: The role of informal and formal supports." *Health in aging: Sociological issues and policy directions*. Edited by R.A. Ward and S.S. Tobin. New York: Springer, 133–157.
- George, L.K. and L.P. Gwyther. 1986. "Caregiver well-being: A multidimensional examination of family caregivers of demented adults." *Gerontologist*. 26, 3: 253–259.
- Gibeau, J.L. and J.W. Anastas. 1989. "Breadwinners and caregivers: Interviews with working women." *Journal of Gerontological Social Work*. 14, 1–2: 19–40.
- Gignac, M.A.M., E.K. Kelloway and B.H. Gottlieb. 1996. "The impact of caregiving on employment: A mediational model of work-family conflict." *Canadian Journal on Aging*. 15, 4: 525–542.
- Given, C.W., C.E. Collins and B.A. Given. 1988. "Sources of stress among families caring for relatives with Alzheimer's disease." *Nursing Clinics of North America*. 23, 1: 69–82.
- Glendinning, C. 1992. *The costs of giving care: Looking inside the household*. London, UK: Her Majesty's Stationery Office (HMSO).
- Gorey, K.M., R.W. Rice and G.C. Brice. 1992. "The prevalence of eldercare responsibilities among the workforce population." *Research On Aging*. 14, 3: 399–418.
- Gottlieb, B.H. and A.M. Gignac. 1996. "Content and domain specificity of coping among family caregivers of persons with dementia." *Journal of Aging Studies*. 10, 2: 137–155.
- Gottlieb, B.H., E.K. Kelloway and M. Fraboni. 1994. "Aspects of eldercare that place employees at risk." *Gerontologist*. 34, 6: 815–821.

Green, C.P. 1991. "Clinical considerations. Midlife daughters and their aging parents." *Journal of Gerontological Nursing*. 17: 6–12.

Hallman, B.C. and A.E. Joseph. 1995. *Lost in space: Gendered geographies of eldercare provision*. Vancouver: Paper presented at the 24th Annual Scientific and Education Meeting of the Canadian Association on Gerontology.

Harlton, S., N. Keating and J. Fast. 1998. "Defining eldercare for policy and practice: Perspectives matter." *Family Relations*. 47, 3: 281–288.

Himes, C.L., A.K. Jordan and J.I. Farkas. 1996. "Factors influencing parental caregiving by adult women: Variations by care intensity and duration." *Research on Aging*. 18, 3: 349–370.

Hirsch, C. 1996. "Understanding the influence of gender role identity on the assumption of family caregiving roles by men." *International Journal of Aging and Human Development*. 42, 2: 103–121.

Hooyman, N. 1983. "Social support networks in services to the elderly." *Social support networks: Informal helping in the human services*. Edited by J.K. Whittaker and J. Garbereio. New York: Aldene, 133–164.

Hooyman, N. and J. Gonyea. 1995. *Feminist perspectives on family care: Policies for gender justice*. London: Sage.

Hooyman, N., J. Gonyea and R. Montgomery. 1985. "The impact of in-home services termination on family caregivers." *Gerontologist*. 25, 2: 141–145.

Ingersoll-Dayton, B., M.E. Starrels and D. Dowler. 1996. "Caregiving for parents and parents-in-law: Is gender important?" *Gerontologist*. 36: 483–491.

Jacobson, D. 1987. "The cultural context of social support and support networks." *Medical Anthropology Quarterly*. 1, 1: 42–67.

Joseph, A.E. and B.C. Hallman. 1996. "Caught in the triangle: The influence of work and elder location on work-family balance." *Canadian Journal on Aging*. 15, 3: 393–412.

Jutras, S. and F. Veilleux. 1991. "Informal caregiving: Correlates of perceived burden." *Canadian Journal on Aging*. 10, 1: 40–55.

Kaden, J. and S.A. McDaniel. 1990. "Caregiving and care-receiving: A double bind for women in Canada's aging society." *Journal of Women and Aging*. 2: 3–26.

Katz, S. and C.A. Akpom. 1976. "A measure of primary sociobiological functions." *International Journal of Health Services*. 6: 493–507.

Keating, N. 1991. *Aging in rural Canada*. Toronto: Butterworths.

Keating, N., J. Fast, I. Connidis, M. Penning and J. Keefe. 1997. "Bridging policy and research in eldercare." *Canadian Journal on Aging/Canadian Public Policy*. Supplement (Spring): 22–41.

Keating, N., K. Kerr, S. Warren, M. Grace and D. Wertenberger. 1994. "Who's the family in family caregiving?" *Canadian Journal on Aging*. 13, 2: 268–286.

Keefe, J. and P. Fancey. 1996. *Family involvement in long-term care*. Halifax: Nova Scotia Centre on Aging.

Kemper, P. 1992. "The use of formal and informal home care by the disabled elderly." *Health Services Research*. 27: 421–451.

Killeen, M. 1990. "The influence of stress and coping on family caregivers' perceptions of health." *International Journal of Aging and Human Development*. 30, 3: 197–211.

Kossek, E.E., B.J. DeMarr, K. Backman and M. Kollar. 1993. "Assessing employees, emerging elder care needs and reactions to dependent care benefits." *Public Personnel Management*. 22, 4: 617–638.

Kramer, B.J. and S. Kipnis. 1995. "Eldercare and work-role conflict: Toward an understanding of gender differences in caregiver burden." *Gerontologist*. 35, 3: 340–348.

Lawton, M.P. and E.M. Brody. 1969. "Assessment of older people: Self-maintaining and instrumental activities of daily living." *Gerontologist*. 9: 179–186.

Lechner, V.M. 1993. "Support systems and stress reduction among workers caring for dependent parents." *Social Work*. 38, 4: 461–469.

Lee, G.R., J.W. Dwyer and R.T. Coward. 1990. "Residential location and proximity among impaired elderly parents." *Rural Sociology*. 55, 4: 579–589.

Lin, G. and P.A. Rogerson. 1995. "Elderly parents and the geographic availability of their adult children." *Research on Aging*. 17, 3: 303–331.

Logan, R. 1994. "Voluntary part-time workers." *Perspectives on Labour and Income*. 6: 3: 18–23.

MacBride-King, J. 1990. *Work and family: Employment challenge of the 90's*. Conference Board of Canada Report No. 59-90. Ontario: The Conference Board of Canada.

Martin Matthews, A. and L.D. Campbell. 1995. "Gender roles, employment and informal care." *Connecting gender and ageing: A sociological approach*. Edited by S. Arber and J. Ginn. Buckingham: Open University, 129–143.

Martin Matthews, A. and C.J. Rosenthal. 1996. *Women, work and caregiving: How much does a great job really make?* Independence and Economic Security of the Older Population, Research Paper No. 5. Hamilton: McMaster University.

McCarty, E.F. 1996. "Caring for a parent with Alzheimer's disease: Process of daughter caregiver stress." *Journal of Advanced Nursing*. 23: 792–803.

Medjuck, S., M. O'Brien and C. Tozer. 1992. "From private responsibility to public policy: Women and the cost of caregiving to elderly kin." *Atlantis*. 17, 2: 44-58.

Miller, B. and S. McFall. 1991. "Stability and change in the informal task support network of frail older persons." *Gerontologist*. 31, 6: 735-745.

Montgomery, R.J.V., J.G. Gonyea and N.R. Hooyman. 1985. "Caregiving and the experience of subjective and objective burden." *Family Relations*. 34: 19-26.

Morris, R.G., R.T. Woods, K.S. Davies and L.W. Morris. 1991. "Gender differences in carers of dementia sufferers." *British Journal of Psychiatry*. 158 (Supplement 10): 69-74.

Mutschler, P.H. 1994. "From executive suite to production line: How employees in different occupations manage eldercare responsibilities." *Research on Aging*. 16, 1: 7-26.

National Advisory Council on Aging (NACA). 1990. *The NACA position on informal caregiving: Support and enhancement*. Ottawa: National Advisory Council on Aging.

Neal, M.B., N.J. Chapman, B. Ingersoll-Dayton and A.C. Emlen. 1993. *Balancing work and caregiving for children, adults and elders*. Newbury Park, CA: Sage.

Neal, M.B., N.J. Chapman, B. Ingersoll-Dayton, A.C. Emlen and L. Boise. 1990. "Absenteeism and stress among employed caregivers of the elderly, disabled adults and children." *Aging and caregiving*. Edited by D.E. Biegel and A. Blum. London: Sage, 160-184.

Neysmith, S.M. 1991. "From community care to a social model of care." *Women's caring: Feminist perspectives on social welfare*. Edited by C.T. Baines, P.M. Evans and S.M. Neysmith. Toronto: McClelland and Stewart, 272-299.

Nichols, L.S. and V.W. Junk. 1997. "The sandwich generation: Dependency, proximity and task assistance needs of parents." *Journal of Family and Economic Issues*. 18: 299-326.

Noelker, L.S. and R.W. Wallace. 1985. "The organization of family care for impaired elderly." *Journal of Family Issues*. 6: 23-44.

Parker, G. 1990. *With due care and attention: A review of research on informal care*. London: Family Policy Studies Centre.

Parks, S.H. and M. Pilisuk. 1991. "Caregiver burden: Gender and the psychological costs of caregiving." *American Journal of Orthopsychiatry*. 61, 4: 501-509.

Penning, M.J. and N.C. Keating. In review. "Self, informal and formal care: Partnerships in community-based and residential long-term care settings." *Canadian Journal on Aging*.

Penrod, J.D., R.A. Kane, R.L. Kane and M.D. Finch. 1995. "Who cares? The size, scope and composition of the caregiver support system." *Gerontologist*. 35: 489-497.

Qureshi, H. 1990. "A research note on the hierarchy of obligations among informal carers: A response to Finch and Mason." *Ageing and Society*. 10: 455-458.

Robins, P.V., N.L. Mace and M.J. Lucas. 1982. "The impact of dementia on the family." *Journal of the American Medical Association*. 248, 3: 333-335.

Rankin, E.D. 1990. "Caregiver stress and the elderly: A familial perspective." *Journal of Gerontological Social Work*. 15, 1-2: 57-73.

Rosenthal, C.J., A. Martin Matthews and S.H. Matthews. 1996. "Caught in the middle? Occupancy in multiple roles and help to parents in a national probability sample of Canadian adults." *Independence and Economic Security of the Older Population*. Research paper 4: 1-38.

Sanborn, B. and S. Bould. 1991. "Intergenerational caregivers of the oldest old." *Marriage and Family Review*. 16, 1-2: 125-142.

Scharlach, A.E. 1989. "A comparison of employed caregivers of cognitively impaired and physically impaired elderly persons." *Research on Aging*. 11, 2: 225-243.

—. 1994. "Caregiving and employment: Competing or complementary roles?" *Gerontologist*. 34, 3: 378-385.

Scharlach, A.E. and S.L. Boyd. 1989. "Caregiving and employment: Results of an employee survey." *Gerontologist*. 29, 3: 382-387.

Scharlach, A.E., B.F. Lowe and E.L. Schneider. 1991. *Elder care and the workforce*. Toronto: Lexington.

Schellenberg, G. 1997. "The changing nature of part-time work." *Perception*. 21, 2: 9-12.

Schulz, R. and G.M. Williamson. 1991. "A 2-year longitudinal study of depression among Alzheimer's caregivers." *Psychology and Aging*. 6, 4: 569-578.

Shapiro, E. 1995. "Case management in long-term care: Exploring its status, trends and issues." *Journal of Case Management*. 4, 2: 43-47.

Spitze, G. and J. Logan. 1990. "More evidence on women (and men) in the middle." *Research on Aging*. 12, 2: 182-198.

- Statistics Canada. 1995. "National population health survey: Residents of health care institutions." *The Daily*. <<http://www.statcan/english/daily>>. Released October 27, 1995.
- Stoller, E.P. 1983. "Parental caregiving by adult children." *Journal of Marriage and the Family*. 45: 335-342.
- Stone, R. 1991. "Defining family caregivers of the elderly: Implications for research and public policy." *Gerontologist*. 31: 724-725.
- Stone, R.I. and P.F. Short. 1990. "The competing demands of employment and informal caregiving to disabled elders." *Medical Care*. 28, 6: 513-526.
- Stone, R., G.L. Cafferata and J. Sangl. 1987. "Caregivers of the frail elderly: A national profile." *Gerontologist*. 27: 616-626.
- Stueve, A. and L. O'Donnell. 1989. "Interactions between women and their elderly parents." *Research on Aging*. 11, 3: 331-353.
- Tennstedt, S.L., S. Crawford and J.B. McKinlay. 1993. "Determining the pattern of community care: Is coresidence more important than caregiver relationship?" *Journal of Gerontology*. 48, 2: S74-S83.
- Thornton, M.C., S.I. White-Means and H.K. Choi. 1993. "Sociodemographic correlates of the size and composition of informal caregiver networks among frail ethnic elderly." *Journal of Comparative Family Studies*. 24: 235-250.
- Walker, A.J., S.S.K. Martin and L.L. Jones. 1992. "The benefits and costs of caregiving and care receiving for daughters and mothers." *Journal of Gerontology*. 47, 3: S130-S139.
- Walker, A.J., C.C. Pratt and L. Eddy. 1995. "Informal caregiving to aging family members. A critical review." *Family Relations*. 44: 402-411.
- Walker, A.J., C.C. Pratt, H. Shin and L.L. Jones. 1989. "Why daughters care: Perspectives of mothers and daughters in a caregiving situation." *Aging parents and adult children*. Edited by J.A. Mancini. Lexington, Mass.: Lexington, 199-209.
- Walker, A.J., C.C. Pratt, H. Shin and L.L. Jones. 1990. "Motives for parental caregiving and relationship quality." *Family Relations*. 39: 51-56.
- Wallace, R.W. and L.S. Noelker. 1984. *Conceptualizing family caregiving: An application of role theory*. San Antonio: Paper presented to the 37th Annual Scientific Meeting of the Gerontological Society of America, November 1984.
- Wenger, G.C. 1997. *Social networks and the prediction of elderly people at risk*. Paper presented at the Psychiatry of Old Age Conference, April 1997. Wenger, Windermere, Bangor, U.K.: University of Wales, Centre for Social Policy Research and Development.
- Westbrook, M.T. and L.L. Viney. 1983. "Age and sex differences in patients' reactions to illness." *Journal of Health and Social Behavior*. 24, 4: 313-324.

White-Means, S. and C.F. Chang. 1994. "Informal caregivers' leisure time and stress." *Journal of Family and Economic Issues*. 15, 2: 117-136.

Wilkins, R. and O.B. Adams. 1983. "Health expectancy in Canada: Late 1970s demographic, regional and social dimensions." *American Journal of Public Health*. 73: 1073-1080.

Zarit, S.H., K.E. Reever and J. Bach-Peterson. 1980. "Relatives of the impaired elderly: Correlates of feelings of burden." *Gerontologist*. 20, 6: 649-655.

Zarit, S.H., P.A. Todd and J.M. Zarit. 1986. "Subjective burden of husbands and wives as caregivers: A longitudinal study." *Gerontologist*. 26, 3: 260-266.

